RAPID5 Multidimensional Health Assessment Questionnaire (MDHAQ)

YOUR NAME:_____ **Date of Birth:** _____ **Today's Date:**_____

1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○○○○○○○○○○○○○○○○○○○○○ **PAIN AS BAD AS IT COULD BE**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
LEFT FINGERS	☐0	☐1	☐2	☐3	RIGHT FINGERS	☐0	☐1	☐2	☐3
LEFT WRIST	☐0	☐1	☐2	☐3	RIGHT WRIST	☐0	☐1	☐2	☐3
LEFT ELBOW	☐0	☐1	☐2	☐3	RIGHT ELBOW	☐0	☐1	☐2	☐3
LEFT SHOULDER	☐0	☐1	☐2	☐3	RIGHT SHOULDER	☐0	☐1	☐2	☐3
LEFT HIP	☐0	☐1	☐2	☐3	RIGHT HIP	☐0	☐1	☐2	☐3
LEFT KNEE	☐0	☐1	☐2	☐3	RIGHT KNEE	☐0	☐1	☐2	☐3
LEFT ANKLE	☐0	☐1	☐2	☐3	RIGHT ANKLE	☐0	☐1	☐2	☐3
LEFT TOES	☐0	☐1	☐2	☐3	RIGHT TOES	☐0	☐1	☐2	☐3
NECK	☐0	☐1	☐2	☐3	BACK	☐0	☐1	☐2	☐3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○○○○○○○○○○○○○○○○○○○○○ **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

DO NOT WRITE BELOW THIS – FOR DOCTOR'S USE ONLY – MD Global

VERY WELL ○○○○○○○○○○○○○○○○○○○○○ VERY POORLY

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

FN 0-10 ☐

1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

PN 0-10 ☐

PTGL 0-10 ☐

RAPID3 0-30 ☐

JT CT 0-10 ☐

1=0.2 2=0.4 3=0.6 4=0.8 5=1.0 6=1.3 7=1.5 8=1.7 9=1.9 10=2.1 11=2.3 12=2.5 13=2.7 14=2.9 15=3.1 16=3.3 17=3.5 18=3.8 19=4.0 20=4.2 21=4.4 22=4.6 23=4.8 24=5.0 25=5.2 26=5.4 27=5.6 28=5.8 29=6.0 30=6.3 31=6.4 32=6.7 33=6.9 34=7.1 35=7.3 36=7.5 37=7.7 38=7.9 39=8.1 40=8.3 41=8.5 42=8.8 43=9.0 44=9.2 45=9.4 46=9.6 47=9.8 48=10

RAPID4 0-40 ☐

MDGL:0-10 ☐

RAPID5 0-50 ☐

5. Please check (√) if you have experienced any of the following over the last month:

__ Fever
__ Weight gain (>10 lbs)
__ Weight loss (<10 lbs)
__ Feeling sickly
__ Headaches
__ Unusual fatigue
__ Swollen glands
__ Loss of appetite
__ Skin rash or hives
__ Unusual bruising or bleeding
__ Other skin problems
__ Loss of hair
__ Dry eyes
__ Other eye problems
__ Problems with hearing
__ Ringing in the ears
__ Stuffy nose
__ Sores in the mouth
__ Dry mouth
__ Problems with smell or taste
__ Lump in your throat
__ Cough
__ Shortness of breath
__ Wheezing
__ Pain in the chest
__ Heart pounding (palpitations)
__ Trouble swallowing
__ Heartburn or stomach gas
__ Stomach pain or cramps
__ Nausea
__ Vomiting
__ Constipation
__ Diarrhea
__ Dark or bloody stools
__ Problems with urination
__ Gynecological (female) problems
__ Dizziness
__ Losing your balance
__ Muscle pain, aches, or cramps
__ Muscle weakness
__ Paralysis of arms or legs
__ Numbness or tingling of arms or legs
__ Fainting spells
__ Swelling of hands
__ Swelling of ankles
__ Swelling in other joints
__ Joint pain
__ Back pain
__ Neck pain
__ Use of drugs not sold in stores
__ Smoking cigarettes
__ More than 2 alcoholic drinks per day
__ Depression - feeling blue
__ Anxiety - feeling nervous
__ Problems with thinking
__ Problems with memory
__ Problems with sleeping
__ Sexual problems
__ Burning in sex organs
__ Problems with social activities

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? No Yes
If "No," please go to Item 7. If "**Yes**," **please indicate the number of minutes**_____, **or hours** _____
until you are as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check ( ) **only one.**
Much **B**etter (1), **B**etter (2), the **S**ame (3), **W**orse (4), **M**uch **W**orse (5) than one week ago

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please check** ( ) **only one.**
3 or more times a week (3) 1-2 times per month (1)
1-2 times per week (2) Do not exercise regularly (0) Cannot exercise due to disability/ handicap (9)

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?
FATIGUE IS

FATIGUE IS A
NO PROBLEM 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 MAJOR PROBLEM

10. Over the last 6 months have you had: [Please check (√)**]**

No Yes An operation
No Yes Inpatient hospitalization
No Yes A new illness, accident or trauma
No Yes An important new symptom
No Yes Side effect(s) of any drug
No Yes Smoke cigarettes regularly
No Yes Change(s) of arthritis drugs or other drugs
No Yes Change(s) of address
No Yes Change(s) of marital status
No Yes Change job or work duties, quit work, retired
No Yes Change of medical insurance, Medicare, etc.
No Yes Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

_____

_____

SEX: Female, Male **ETHNIC GROUP:** Asian, Black, Hispanic, White, Other_____

Your Occupation _____ **Circle the number of years of school you have completed**:
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

Work Status: Full-time Part-time Disabled
Homemaker Self-Employed Retired
Seeking work Other_____ **Record your weight: _____ lbs. height: _____ inches**

Your Name_____ **Date of Birth** _____ **Today's Date** _____

Thank you for completing this questionnaire to help keep track of your medical care.

Max I. Hamburger, MD, FACP
Paul E. Schulman, MD
Sara J. Johnson, MD

Peter M Rumore, MD FACP
Howard Blumstein, MD
Hong Xu, MD
L.Manuela Marinescu, MD

Lucas M McCaffrey, DO
Mark A. Goldstein, MD
Maryann J. Lee, MD

Rheumatology Associates of Long Island, LLP

Practice Limited to
Arthritis and Rheumatology
Diplomates American Board of Internal Medicine
Sub Specialty Rheumatology

7 Medical Drive
Port Jefferson Sta, NY 11776
Phone: 631 928-4885
Fax 631 928-2944

315 Middle Country Road
Smithtown, NY 11787
Phone: 631 360-7778
Fax: 631 979-1609

1895 Walt Whitman Road
Melville, NY 11747
Phone 631 249-9525
Fax: 631 420-1526

554 East Main Street
Riverhead, NY 11901
Phone: 631 656- 7171
Fax: 631 779-3597

1200 South Avenue
Staten Island, NY 10314
Phone: 718 224-1680
Fax: 718 224-1680

TO: OUR PATIENTS

REGARDING: CHECK-IN AND CHECK-OUT PROCEDURES
CO-PAYMENT

RALI has procedures for check-in, check-out, return visit scheduling, and co-payment collection. At the check-in desk, the staff member will present you with a copy of your:

1) **Patient Information Sheet. You will be asked to review the information and to be certain that it is correct. If the information needs to be updated, please inform the staff at that time. If there is no need to make corrections you will be asked to sign off on the sheet we will do this at every visit. We recognize that this may seem repetitious to those of you whose information remains unchanged. Our staff handles approximately 100 pieces of return mail a week from patients whose information has changed. Thus, we are taking these steps to ensure our ability to communicate with you, and on your behalf when necessary.**

2) **At the check-in desk, you will also be reminded that a co-payment is due at the time of your visit, and the co-payment will be collected at the check-out. Collection of co-payments be the office is required by both insurers and by Medicare. RALI does not make Medicare or insurance company law, or insurance company policy. The check-in and check-out staff is not empowered to make exceptions to co-payment collection policy. When your insurance plan requires a referral for you to see one of the doctors, we must have that referral or we may be forced to re-schedule your visit.**

3) **You must visit the check-out desk before leaving the office. The check-out desk will schedule your return visit. The scheduling of return visits is to be done at the time of check-put. We ask for your cooperation in the regard.**

PATIENT INFORMATION

DATE_____

NAME_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS_____CITY_____ ZIP_____

EMAIL ADDRESS_____

HOME PHONE_____CELL PHONE_____

MARTIAL STATUS S_____M_____W_____D_____ BIRTHDATE_____ AGE_____

Due to recent legislation changes, the government is requiring medical facilities to collect the following information.
Please circle all that applies

Ethnicity/Race	Ethnic Group
Black or African American	Not Hispanic or Latino
Hispanic/Latino	
White/Caucasian	

RFERRING DOCTOR_____TEL#_____NPI#_____

EMPLOYER NAME_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

NAME OF SPOUSE_____
(LAST) (FIRST) (MIDDLE INITIAL)

SOUPSE'S EMPLOYER_____OCCUPATION_____PHONE#_____

WORK ADDRESS_____CITY_____ZIP_____

IN CASE OF AN EMERGENCEY NOTIFY/RELATIONSHIP_____PHONE#_____

RETAIL PHARMACY_____PHONE #_____

MAIL ORDER PHARMACY _____PHONE #_____

PRIMARY INSURED_____ INSURANCE COMPANY_____

ID #_____ GROUP #_____

SECONDARY INSURED_____INSURANCE COMPANY_____

ID#_____GROUP#_____

ASSIGNMENT OF BENEFITS	RELEASE OF INFORMATION
I authorize payment of medical benefits to myself Or the named provider for professional services rendered	I authorize the release of any medical information Necessary to process this claim
SIGNED_____DATE_____ (Subscriber)	SIGNED_____DATE_____ (Subscriber)

I have reviewed the above information and there are no changes at this time.

Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date Initials Date

_____ ____ _____ _____ _____ ____ _____ ____ _____ ____ _____ ____ _____ _____

Patient Name_____ Date_____

Please fill in names of all doctors next to their Specialty

Allergist

Cardiologist

Chiropractor

Dermatologist

Endocrinologist

ENT

Gastroenterologist

Nephrologist

Neurologist

OB/GYN

Oncologist/Hematologist

Ophthalmologist

Orthopedist

Pain Management

Family Doctor/PCP/Internist

Psychiatrist

Psychologist

Pulmonologist

Urologist

Vascular

Today's Date_____

Office use only: Physician Reviewed: ☐

Revised 9.22.16

Health History Questionnaire

All Questions contained in this questionnaire are strictly confidential and will become part of your medical record

Last Name: _____ First Name: _____
DOB: _____

F ☐
M ☐

Allergies

Check here if none ☐

(Medication or Other)

Please list any allergy	Reaction you had

Medications

(List your prescribed drugs and over the counter drugs, such as vitamins)

Name of drug	Strength	Frequency	Start date (if known)

Past Medications

Please review this list of arthritis medications. Check circle any that you have taken in the PAST

Anti-Inflammatories (NSAIDs) & Steriods
- Arthrotec
- Celebrex
- Clinoril/Sulinda
- Daypro/Oxaprozin
- Dolobid Diflunisal
- Feldene/Piroxicam
- Indocin
- Lodine/Etodolac
- Motrin/Ibuprofen/Aleve
- Naprosyn
- Ketoprofen
- Voltaren/Diclofenac
- Other:

Rheumatic Biologics
- Actemra
- Cimzia
- Enbrel
- Humira
- Orencia
- Remicade
- Rituxan
- Simponi Aria
- Benlysta
- Stelara
- Cosentyx
- Other:

Pain Relievers/Narcotics
- Hydrocodone
- Oxycodone
- Codeine
- Fentanyl
- Dilaudid
- Methamphetamine
- Methadone
- Demerol
- Dexedrine
- Other:

Fibromyalgia Medication
- Lyrica
- Cymbalta
- Savella
- Gabapentine/Neurotin
- Tramadol/Ultram/Ultracet
- Cyclobenzaprine
- Nortriptyline
- Amitriptyline/Elavil
- Other:

Disease Modifying Anti-Rheumatic Drugs (DMARDS)
- Arava (leflunomide)
- Cytoxan (Cyclophosphamide)
- Xeljanz/Tofacitinib
- Otezla
- Imuran(Azathioorine)
- Methotrexate (Rheumatrex)
- Neoral (Cyclosporine)
- Plaquenil (Hydroxychloriquine)
- Prednisone/ Cortisone
- Sulfasalazine (Azulfidine)
- Other:

Osteoporosis
- Fosamax/Alendronate
- Actonel/Risedronate
- Boniva/Ibandronic acid
- Zoledronic acid/Reclast
- Prolia
- Atelvia
- Estrogen
- Evista/Raloxfiene
- Forteo
- Other:

Gout Medication
- Clochicine
- Uloric
- Krystexxa
- Probenecid
- Lopurin/ Allopurinol
- Other:

Knee Injections
- Orthovisc
- Synvisc
- Euflexxa
- Hyalgan
- Supartz
- Other:

Please list any other past medications your doctor should aware of:

_____

_____

Last Name:_____ **First Name**_____

Personal Health History

Circle any health problems that other doctors have diagnosed you with

Arthritis	**GERD**
Asthma	**Heart problems _____(type)**
Cancer_____(type)	**Hepatitis A,B, or C**
Cataract	**High blood pressure**
Blood Clot	**Kidney Problems**
Colitis	**Osteoarthritis**
COPD	**Pneumonia**
Depression	**Seizures**
Diabetes I or II	**Stroke**
High Cholesterol	**Depression**
Emphysema	**Thyroid problems: Hypo/Hyper**
Fibromyalgia	**Bone Fracture**
Anxiety	**TB/Positive PPD**

Surgical History

Date	**Procedure**

Last Name: _____First Name: _____

Family Health History

Family Member	Age if Alive	Age at Death	Significant Health Problems/Cause of Death
Father			
Mother			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			
Sibling (Male/Female)			

Child (Male/Female)	D.O.B	Age at Death	Significant Health Problems/Cause of Death

Last Name:_____ First Name:_____

Social History

Marital Status:

Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Exercise:

None

Type:_____

Frequency:_____ per week

Caffeine:

None ☐ Coffee ☐ Tea ☐ Cola ☐

# of Cups per Day

Tobacco:

Yes ☐ No ☐

Cigarettes ☐ Cigars ☐

# of years_____ or Year that you Quit_____

Alcohol:

Yes ☐ No ☐

How many drinks per week?_____

Recreational drugs: *(non-medical)*

Yes ☐ No ☐

If yes please list:_____

Last Name: _____ First Name: _____

RHEUMATOLOGY ASSOCIATES OF LONG ISLAND

7 Medical Drive	315 Middle Country Rd	1895 Walt Whitman Rd	554 East Main St	1200 South Avenue
Port Jefferson Sta.,NY 11776	Smithtown, NY 11787	Melville, NY11747	Riverhead, NY 11901	Staten Island, NY 1110314
Phone: (631) 928-4885	Phone: (631) 360-7778	Phone: (631) 249-9525	Phone: (631) 656-7171	Phone: (718) 698-3777
Fax: (631) 928-2944	Fax: (631) 979-1609	Fax: (631) 979-1609	Fax: (631) 9791609	Fax: (718) 698- 8777

Name_____ Account_____

Notification Policy

It is our policy not to release confidential and/or unauthorized information by home telephone, answering Machine, work telephone, voice mail, cell phone/ or pager. When returning calls and an answering machine picks up; we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___yes ___no Home telephone_____

___yes ___no Home Answering Machine_____

___yes ___no Fax Home_____

___ yes ___no Fax Work_____

___yes ___no Work phone/Voicemail_____

___yes ___no Cell phone/Voicemail_____

___yes ___no E-mail_____

___yes ___no Pager_____

Please list names of authorized people we may leave messages with (i.e. spouse, boyfriend, girlfriend, parent, grandparent etc.):

Name_____ Relationship_____ yes __ no__
Name_____ Relationship_____ yes __ no__
Name_____Relationship_____ yes __ no__

Who may we discuss your financial situation with?

Name_____Relationship_____ yes__ no__
Name_____Relationship_____ yes__ no__

_____ _____
SIGNATURE (Patient/Guardian) **DATE**

Koos, JR. Knee Survey

Name:_____ Date:_____

Date of Birth:_____

Instructions: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.
Answer every question by checking off the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness

The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation or restriction or slowness in the ease with which you move your knee joint

1) How severe is your knee stiffness after first wakening in the morning?

None ☐	Mild ☐	Moderate ☐	Severe☐	Extreme ☐
0	1	2	3	4

Pain

What amount of knee pain have you experienced the **last week** during the following activities?

2) Twisting/Pivoting on your knee

None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme ☐
0	1	2	3	4

3) Straightening knee fully

None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme ☐
0	1	2	3	4

4) Going Up or Down stairs

None ☐	Mild ☐	Moderate ☐	Severe☐	Extreme ☐
0	1	2	3	4

5) Standing upright

None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme ☐
0	1	2	3	4

Function

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6) Rising from sitting

None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme ☐
0	1	2	3	4

7) Bending to floor/pick up an object

None ☐	Mild ☐	Moderate ☐	Severe ☐	Extreme ☐
0	1	2	3	4

Max I. Hamburger, MD, FACP
Paul E. Schulman, MD
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Peter M. Rumore, MD FACP

Howard Blumstein, MD
Hong Xu, MD
L. Manuela Marinescu, MD
Lucas McCaffrey

Daniel Torres
Maryanne Lee MD
Mark Goldstein MD

Rheumatology Associates of Long Island, LLP
Practice Limited to
Arthritis and Rheumatology
Diplomates American Board of Internal Medicine
Sub specialty Rheumatology

Seven Medical Dr.
Port Jefferson Sta., NY 11776

Phone: 631 928-4885
Fax: 631 928-2944

315 Middle Country Rd.
Smithtown, NY 11787

Phone: 631 360-7778
Fax: 631 979-1609

1895 Walt Whitman Rd.
Melville, NY 11747

Phone: 631 249-9525
Fax: 631 420-1526

887 Old Country Rd.
Riverhead, NY 11901

Phone: 631 727-1989
Fax: 631 727-6272

1200 South Ave.
Staten Island, NY 10314

Phone: 718 698-3777
Fax: 718 698-8777

BASDAI

1. How would you describe the overall level of fatigue/tiredness you have experienced?

None 0 1 2 3 4 5 6 7 8 9 10 Very severe

2. How would you describe the overall Level of inflammatory neck, back or hip pain you have had?

None 0 1 2 3 4 5 6 7 8 9 10 Very severe

3. How would you describe the overall level of pain/swelling in joints other than neck, back or hips you have had?

None 0 1 2 3 4 5 6 7 8 9 10 Very severe

4. How would you describe the overall level of discomfort you have had from any areas tender to touch or pressure?

None 0 2 3 4 5 6 7 8 9 10 Very severe

5. How would you describe the overall level of morning stiffness you have had from the time you wake up?

None 0 1 2 3 4 5 6 7 8 9 10 Very severe

6. How long does your morning stiffness last from the time you wake up?

0 hrs (=0) 1/2 hr (=2.5) 1 (=5) 1 1/2 hr (=7.5) 2 hrs (=10)

1. Add the scores from questions 1 through 4	
2. Add the scores of questions 5 and 6	
3. Add the totals from step 1 and 2 above	
4. Divide the total from step 3 above by 5	

Current Score

Patient Signature_____