Multi-Dimensional Health Assessment Questionnaire

This questionnaire helps us treat your symptoms for your condition(s) more efficiently.
We ask that you fill this form out as a time-saving measure for when you are brought back to your patient room.

Today's Date:_____ **Your Full Name:** _____ **DOB:** _____

1. What is the **main** reason you are here to see the doctor today?

   _____
2. Do you need any prescription refills or referrals to another physician? YES ☐ NO ☐
   What are the prescriptions/specialist referrals you are requesting?
3. Please review attached medication list. ***This is what we currently have on file for your medications.*** If we are missing medications, please write it in on the list. If dosages have been changed, please let us know. Include over-the-counter drugs and supplements. Also, please note if you are having any side effects on each medication. **It is important to know exactly what you are taking to avoid medication errors.**
4. How much pain have you had because of your condition ***over the past week***? Please place a mark on the line below to indicate how severe your pain has been:
   NO PAIN ----------PAIN AS BAD AS IT COULD BE
5. Considering all the ways in which illness and health conditions may affect you at this time, please place a mark on the line to show how you feel you are doing:
   VERY WELL ----------VERY POORLY
6. Please mark the ONE best answer for your abilities at this time.
   There are no wrong or right answers, so please give us an honest assessment of how you feel as of right now.
   AT THIS MOMENT, are you able to:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do at this time
a. Dress yourself, including tying shoelaces, doing buttons, or zippers?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed unassisted?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down and pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on or off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good night's sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
l. Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

Is there any other information you feel we need or symptoms you would like to inform us of, please indicate that information here:

_____

Thank you for your effort! This information will be added to your chart.

1=0.33 2=0.67 3=1.00 4=1.33 5=1.67 6=2.00 7=2.33 8=2.67 9=3.00 10=3.33
11=3.67 12=4.00 13=4.33 14=4.67 15=5.00 16=5.33 17=5.67 18=6.00 19=6.33 20=6.67
21=7.00 22=7.33 23=7.67 24=8.00 25=8.33 26=8.67 27=9.00 28=9.33 29=9.67 30=10.0

PS **PN** **GL** **MD-GL**

PHYSICIAN'S GLOBAL ASSESSMENT ***VERY WELL*----------*VERY POORLY***