# 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** ☐

# ALLEGRA ARTHRITIS ASSOCIATES, PC

**Edward C. Allegra, MD Richard Haddad, MD Lucille Sullivan, PA-C**

| | | |
|---|---|---|
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| Tax ID: 20-3045848 | | |


## Patient History Form

Name: _____ Birthdate: / /
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Referred here by: (check one) ○Self ○Family ○Friend ○Doctor ○Other Health Professional

Name of person making referral: _____

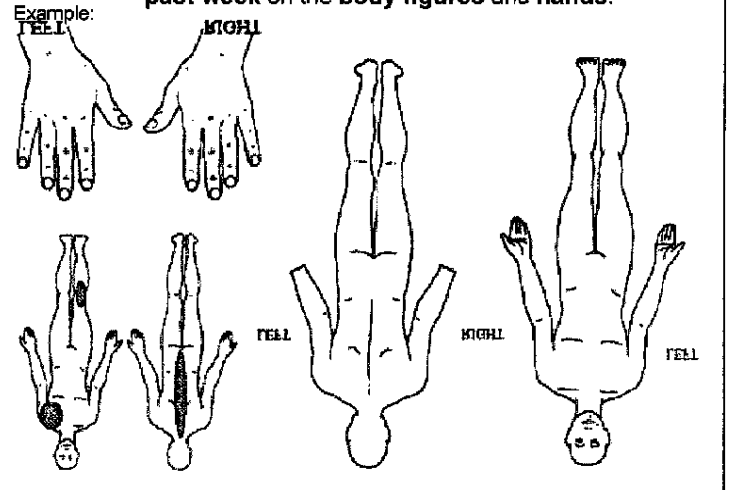
The name of the physician providing your primary medical care: _____

Briefly describe your symptoms: _____

Previous treatment for this problem:

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.




Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797- 808. Used by permission.

| Yourself | | Relative Name/Relationship | Yourself | | Relative Name/Relationship |
|---|---|---|---|---|---|
| | Arthritis (unknown type) | | | Lupus or "SLE" | |
| | Osteoarthritis | | | Rheumatoid Arthritis | |
| | Gout | | | Ankylosing Spondylitis | |
| | Childhood arthritis | | | Osteoporosis | |
| Other arthritis conditions: | | | | | |

Patient's Name _____ Date _____ Physician Initials _____

## SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/ Date of last eye exam ____/____/ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/ Date of last bone densitometry ____/____/

**Constitutional**

- ❑ Recent weight gain
  amount _____ _____
- ❑ Recent weight loss
  amount _____ _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

**Eyes**

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

**Ears-Nose-Mouth-Throat**

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

**Cardiovascular**

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

**Respiratory**

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

**Gastrointestinal**

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

**Genitourinary**

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

**Musculoskeletal**

- ❑ Morning stiffness
  Lasting how long?
  _____Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

**Integumentary (skin and/or breast)**

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

**Neurological System**

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

**Psychiatric**

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

**Endocrine**

- ❑ Excessive thirst

**Hematologic/Lymphatic**

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

**Allergic/Immunologic**

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

## SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

## PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

| | | |
|---|---|---|
| ❑ Cancer | ❑ Heart problems | ❑ Asthma |
| ❑ Goiter | ❑ Leukemia | ❑ Stroke |
| ❑ Cataracts | ❑ Diabetes | ❑ Epilepsy |
| ❑ Nervous breakdown | ❑ Stomach ulcers | ❑ Rheumatic fever |
| ❑ Bad headaches | ❑ Jaundice | ❑ Colitis |
| ❑ Kidney disease | ❑ Pneumonia | ❑ Psoriasis |
| ❑ Anemia | ❑ HIV/AIDS | ❑ High Blood Pressure |
| ❑ Emphysema | ❑ Glaucoma | ❑ Tuberculosis |

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

**Previous Operations**

| *Type* | *Year* | *Reason* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

## FAMILY HISTORY:

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| | Age | Health | Age at Death | Cause |
| Father | | | | |
| Mother | | | | |

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Cancer ❑ _____
❑ Leukemia ❑ _____
❑ Stroke ❑ ❑ _____
❑ Colitis ❑ ❑ _____

❑ Heart disease ❑ _____ H
igh blood pressure _____
❑ _____ B
leeding tendency _____

❑ Rheumatic fever ❑ _____ E
pilepsy _____
❑ _____ ❑ ❑ _____
sthma ___ ❑ ❑ _____

❑ Tuberculosis ❑
❑ Diabetes _____
❑ Goiter _____
❑ ❑ ❑

Patient's Name _____ Date _____ Physician Initials _____

## MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

Type of reaction: _____

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

| Name of Drug | Dose (include strength & number of pills per day) | How long have you taken this medication | Please check: Helped? A Lot | Some | Not At All |
|---|---|---|---|---|---|
| 1. | | | ☐ | ☐ | ☐ |
| 2. | | | ☐ | ☐ | ☐ |
| 3. | | | ☐ | ☐ | ☐ |
| 4. | | | ☐ | ☐ | ☐ |
| 5. | | | ☐ | ☐ | ☐ |
| 6. | | | ☐ | ☐ | ☐ |
| 7. | | | ☐ | ☐ | ☐ |
| 8. | | | ☐ | ☐ | ☐ |
| 9. | | | ☐ | ☐ | ☐ |
| 10. | | | ☐ | ☐ | ☐ |

**PAST MEDICATIONS** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

| Drug names/Dosage | Length of time | Please check: Helped? A Lot | Some | Not At All | Reactions |
|---|---|---|---|---|---|
| **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)** | | ☐ | ☐ | ☐ | |
| **Circle any you have taken in the past**<br>Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac)<br>Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac)<br>Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen)<br>Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) | | | | | |
| **Pain Relievers** | | | | | |
| Acetaminophen (Tylenol) | | ☐ | ☐ | ☐ | |
| Codeine (Vicodin, Tylenol 3) | | ☐ | ☐ | ☐ | |
| Propoxyphene (Darvon/Darvocet) | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| **Disease Modifying Antirheumatic Drugs (DMARDS)** | | | | | |
| Auranofin, gold pills (Ridaura) | | ☐ | ☐ | ☐ | |
| Gold shots (Myochrysine or Solganol) | | ☐ | ☐ | ☐ | |
| Hydroxychloroquine (Plaquenil) | | ☐ | ☐ | ☐ | |
| Penicillamine (Cuprimine or Depen) | | ☐ | ☐ | ☐ | |
| Methotrexate (Rheumatrex) | | ☐ | ☐ | ☐ | |
| Azathioprine (Imuran) | | ☐ | ☐ | ☐ | |
| Sulfasalazine (Azulfidine) | | ☐ | ☐ | ☐ | |
| Quinacrine (Atabrine) | | ☐ | ☐ | ☐ | |
| Cyclophosphamide (Cytoxan) | | ☐ | ☐ | ☐ | |
| Cyclosporine A (Sandimmune or Neoral) | | ☐ | ☐ | ☐ | |
| Etanercept (Enbrel) | | ☐ | ☐ | ☐ | |
| Infliximab (Remicade) | | ☐ | ☐ | ☐ | |
| Prosorba Column | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |

Patient's Name _____ Date _____ Physician Initials_____

**PAST MEDICATIONS Continued**

| | | | | | |
|---|---|---|---|---|---|
| **Osteoporosis Medications** | | | | | |
| Estrogen (Premarin, etc.) | | ☐ | ☐ | ☐ | |
| Alendronate (Fosamax) | | ☐ | ☐ | ☐ | |
| Etidronate (Didronel) | | ☐ | ☐ | ☐ | |
| Raloxifene (Evista) | | ☐ | ☐ | ☐ | |
| Fluoride | | ☐ | ☐ | ☐ | |
| Calcitonin injection or nasal (Miacalcin, Calcimar) | | ☐ | ☐ | ☐ | |
| Risedronate (Actonel) | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| **Gout Medications** | | | | | |
| Probenecid (Benemid) | | ☐ | ☐ | ☐ | |
| Colchicine | | ☐ | ☐ | ☐ | |
| Allopurinol (Zyloprim/Lopurin) | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| Other: | | ☐ | ☐ | ☐ | |
| **Others** | | | | | |
| Tamoxifen (Nolvadex) | | ☐ | ☐ | ☐ | |
| Tiludronate (Skelid) | | ☐ | ☐ | ☐ | |
| Cortisone/Prednisone | | ☐ | ☐ | ☐ | |
| Hyalgan/Synvisc injections | | ☐ | ☐ | ☐ | |
| Herbal or Nutritional Supplements | | ☐ | ☐ | ☐ | |
| Please list supplements: | | | | | |
| | | | | | |
| | | | | | |

**Allegra Arthritis Associates, PC**

## HIPAA - Patient Consent of Information

Allegra Arthritis Associates, PC, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Allegra Arthritis Associates, PC, physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

---

I give my consent to Allegra Arthritis Associates, PC physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with_____relationship_____
_____ with_____relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____
Patient's Name(Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

## HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Allegra Arthritis Associates, PC's Notice of Privacy Practice.

_____I have declined a copy of Allegra Arthritis Associates, PC's Notice of Privacy Practice.

_____ _____
Patient's Signature Date

# ALLEGRA ARTHRITIS ASSOCIATES, PC

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## PATIENT FINANCIAL POLICY

Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

We request all patients complete our Patient Registration Form prior to seeing the doctor and annually thereafter. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

All payments to our office can be made by check, cash, or money order only.

### INSURANCE:

It is the patient's responsibility to provide the office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We may occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the office.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

### CO-PAYS:

Co-payments are due at the time you check in at the front desk **PRIOR** to being seen by your doctor, **NO EXCEPTIONS**. There are ATMs directly across the street from both offices but please come prepared to pay your copay to avoid any inconvenience.

### UN-PAID BALANCES:

We ask that full payment be made at the time of service unless prior arrangements have been made through the billing office. All outstanding balances must be paid **PRIOR** to

seeing the doctor, **NO EXCEPTIONS.** If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due, unless the unpaid balance is less than $8.00. If you have not received a statement, one will be provided to you in the office.

## PAYMENT ARRANGEMENTS

In the event the total balance due is more than you are able to pay; we will make reasonable payment arrangements. Please contact our billing manager to make such arrangements.

## RETURNED CHECKS:

The charge for a returned check is $25 payable by cash or money order. This will be applied to your account and is inclusive of the insufficient funds amount. You will be placed on a "cash only" basis following any returned check.

## UNINSURED PATIENTS:

The fee for a new patient without insurance is $250, with an injection $325. New patient payments are to be in cash only. The fee for an established patient without insurance is $100, with an injection $175. This payment can be made by cash or check. All payments for services are due prior to seeing the doctor.

## MINORS:

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. No patient under the age of 18 will be seen without a parent or guardian present.

## MEDICAL RECORD COPIES/LETTERS OR PAPERWORK SIGNED BY THE DOCTOR:

The fee for copying your medical record is $1.00 per page. The fee for a letter written and signed by the doctor is $30. The fee for filling out paperwork is $30 for the first page, $15 for each additional page. The final cost of these services shall be approved by the billing manager and may change dependent upon the amount of work involved.

I have read and received a copy of Allegra Arthritis Associates' Financial Policy.

Patient Name (print): _____

Patient/Responsible Party Signature: _____

Date: _____