|  |  |  |
| --- | --- | --- |
| HAQ-II (Health Assessment Questionnaire-II) | HAQ-II  (Health Assessment Questionnaire-II) |  |

|  |  |
| --- | --- |
| Name: | DATE OF BIRTH: |

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities **OVER THE PAST WEEK**. Are you able to:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Without any difficulty  (0) | With some difficulty  (1) | With much difficulty  (2) | Unable  (3) |
| Get on and off the toilet? |  |  |  |  |
| Open car doors? |  |  |  |  |
| Stand up from a straight chair? |  |  |  |  |
| Walk outdoors on flat ground? |  |  |  |  |
| Wait in line for 15 minutes? |  |  |  |  |
| Reach and get down a 5-pound object (such as a bag of sugar) from just above your head? |  |  |  |  |
| Go up 2 or more flights of stairs? |  |  |  |  |
| Do outside work (such as yard work)? |  |  |  |  |
| Lift heavy objects? |  |  |  |  |
| Move heavy objects? |  |  |  |  |

How much **PAIN** have you had because of your illness in the **PAST WEEK?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No  Pain |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Very Severe Pain |
| (0) |  | (1) |  | (2) |  | (3) |  | (4) |  | (5) |  | (6) |  | (7) |  | (8) |  | (9) |  | (10) |

How much of a **PROBLEM** has **UNUSUAL FATIGUE** or **TIREDNESS** been for you **OVER THE PAST WEEK?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Fatigue is no problem |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Fatigue is a Severe Problem |
| (0) |  | (1) |  | (2) |  | (3) |  | (4) |  | (5) |  | (6) |  | (7) |  | (8) |  | (9) |  | (10) |

How much of a **PROBLEM** has **SLEEPING** been for you **OVER THE PAST WEEK?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sleep is no problem |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Sleep is a Severe Problem |
| (0) |  | (1) |  | (2) |  | (3) |  | (4) |  | (5) |  | (6) |  | (7) |  | (8) |  | (9) |  | (10) |

How **ACTIVE** has your **ARTHRITIS** been IN THE **LAST 24 HOURS?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Not Active |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Very Active |
| (0) |  | (1) |  | (2) |  | (3) |  | (4) |  | (5) |  | (6) |  | (7) |  | (8) |  | (9) |  | (10) |

When you get up in the **MORNING** do you feel **STIFF**? YES NO

If you answer YES, please write the number of minutes: \_\_\_\_\_\_\_\_\_\_\_\_\_, OR number of hours: \_\_\_\_\_\_\_\_\_\_\_\_\_

Until you are a limber as you will be for the day?