

# 3 MEDICAL ASSESSMENT QUESTIONNAIRE (MAQ)

## (A) PATIENT DETAILS

1. Name
2. Address
3. Date of birth
4. Age
5. Sex
6. Occupation
7. Time (at completion of form)
8. Date
9. Location of patient at present

## (B) PATIENT'S MAIN COMPLAINT/COMPLAINTS

- 1.
- 2.
- 3.
- 4.

## (C) A SHORT DESCRIPTIVE HISTORY OF THE ABOVE PROBLEMS IN THE ORDER THEY OCCURRED

(In the patient's own words, including how long ago the problem(s) started)

**(D) PAIN**

**I. Is there any pain?**

**(If no then pass to section E)**

2. Site of the pain at onset  
or describe in words

**No**

**Yes**

Use diagram 1a (front) or 1b (back)

3. Site of the pain now  
or describe in words

Use diagram 2a (front) or 2b (back)

4. Time since pain began

.... hours

.... minutes

5. Severity of pain now  
(mild, severe, etc.)

6. Since beginning has the pain

Got better/stayed the same/worsened?

7. What is the pain like  
(dull, hot, sharp, etc?)

8. Is the pain

Constant?

Variable?

9. Does the pain go anywhere?

No

Yes

10. Did it come on during activity?

No

Yes

11. How did the pain start?

Suddenly

Gradually

12. Does anything make it better?  
If yes, what?

No

Yes

13. Does anything make it worse?  
If yes, what?

No

Yes

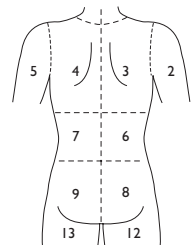
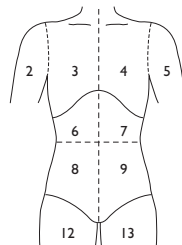
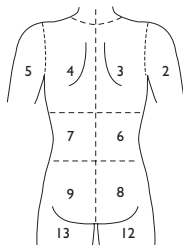
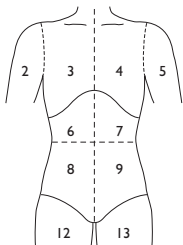


Diagram 1a and 1b  
Site of pain at onset

Diagram 2a and 2b  
Site of pain now

**(E) CHEST**

- |   |   |              |
|---|---|--------------|
| <b>1. Is there any shortness of breath (SOB)?</b> | <b>No</b>   | <b>Yes</b>   |
| 2. How severe is this SOB?                        | Very slight<br>A little tight chested<br>Short of breath at rest<br>Gasping for air |              |
| 3. How long ago did this SOB start?               | .... hours  | .... minutes |
| 4. Does anything make it better?<br>If yes, what? | No  | Yes          |
| 5. Does anything make it worse?<br>If yes, what?  | No  | Yes          |
| <b>6. Is a cough present?</b>                     | <b>No</b>   | <b>Yes</b>   |
| <b>7. Is there any phlegm/spit?</b>               | <b>No</b>   | <b>Yes</b>   |
| 8. Colour of phlegm/spit                          |   |              |
| <b>9. Is the heart pounding in the chest?</b>     | <b>No</b>   | <b>Yes</b>   |

**(F) SICKNESS AND BOWELS**

- |   |  |  |
|---|--|--|
| <b>1. Is there any feeling of sickness?</b> | <b>No</b>                                    | <b>Yes</b>   |
| 2. Time since this feeling began            | .... hours                                   | .... minutes   |
| <b>3. Has there been vomiting?</b>          | <b>No</b>                                    | <b>Yes</b>   |
| 4. Time since vomiting began                | .... hours                                   | .... minutes   |
| 5. Colour of the vomit                      | Food<br>Yellow/green/bile<br>Red/blood/other |  |
| <b>6. Is the appetite changed?</b>          | <b>No</b>                                    | <b>Yes</b>   |
| <b>7. Is the bowel habit changed?</b>       | <b>No</b>                                    | <b>Yes, constipation</b><br><b>Yes, diarrhoea</b>      |
| <b>8. Frequency of moving bowels</b>        | <b>Normally</b><br><b>Now</b>                | <b>.... times per day</b><br><b>.... times per day</b> |
| <b>9. Is this at all painful?</b>           | <b>No</b>                                    | <b>Yes</b>   |
| <b>10. Colour of the bowel motion</b>       |  |  |

**(G) URINE**

<b>1. Is there any pain on passing urine (PU)?</b>	<b>No</b>	<b>Yes</b>
2. Where is this pain felt?		
3. Timing of pain when PU	During	After
<b>4. Any blood seen when PU?</b>	<b>No</b>	<b>Yes</b>
<b>5. Frequency of PU</b>	<b>Normally</b>	<b>.... /day</b>
		<b>.... /night</b>
	<b>Changed to</b>	<b>.... /day</b>
		<b>.... /night</b>

**(H) OTHER COMPLAINTS**

<b>1. Headache present</b>	<b>No</b>	<b>Yes</b>
2. Severity of headache		Mild, fully active Moderate, non-restricting Severe, restricting activity
<b>3. Blackout or collapse</b>	<b>No</b>	<b>Yes</b>
<b>4. Light-headed or faint</b>	<b>No</b>	<b>Yes</b>
<b>5. Sweating</b>	<b>No</b>	<b>Yes</b>
<b>6. Shaking or shivering</b>	<b>No</b>	<b>Yes</b>
<b>7. Feeling weak</b>	<b>No</b>	<b>Yes</b>
<b>8. Muscle ache</b>	<b>No</b>	<b>Yes</b>
<b>9. Vision blurred</b>	<b>No</b>	<b>Yes</b>
<b>10. Earache</b>	<b>No</b>	<b>Yes</b>
<b>11. Nose clear</b>	<b>Yes</b>	<b>No, blocked</b> <b>No, running</b> <b>No, bleeding</b>
<b>12. Sore throat</b>	<b>No</b>	<b>Yes</b>
<b>13. Skin rash present</b>	<b>No</b>	<b>Yes, all body</b> <b>Yes, trunk</b> <b>Yes, limbs</b> <b>Yes, head/neck</b>
14. Is the rash itchy?	No	Yes

**(I) WOMEN ONLY**

- |  |            |                      |
|--|------------|----------------------|
| <b>1. Unusual vaginal bleeding</b>     | <b>No</b>  | <b>Yes, spotting</b> |
|  |            | <b>Yes, light</b>    |
|  |            | <b>Yes, heavy</b>    |
|  |            | <b>Yes, clots</b>    |
| <b>2. Is this linked to any pain?</b>  | <b>No</b>  | <b>Yes</b>           |
| <b>3. Date of last period starting</b> |            |                      |
| <b>4. Was this a “normal” period?</b>  | <b>Yes</b> | <b>No</b>            |

**(J) PAST MEDICAL HISTORY**

- |  |            |            |
|--|------------|------------|
| <b>1. Has this occurred before?</b>                            | <b>No</b>  | <b>Yes</b> |
| 2. What was wrong then?  | Date:      |            |
|  | Diagnosis: |            |
| <b>2. Has the patient been admitted to hospital before?</b>    | <b>No</b>  | <b>Yes</b> |
| 3. For what conditions?  |            |            |
| <b>4. Any other significant episodes of illness or injury?</b> | <b>No</b>  | <b>Yes</b> |
| 5. Dates and conditions  |            |            |

**(K) DRUG HISTORY**

- |  |           |            |
|--|-----------|------------|
| <b>1. Is the patient taking any medications?</b> | <b>No</b> | <b>Yes</b> |
| 2. Drug name                                     | Dosage    |            |
| <b>3. Is the patient allergic to anything?</b>   | <b>No</b> | <b>Yes</b> |
| 4. Allergies to what?                            |           |            |

**CLINICAL EXAMINATION****(N) ALWAYS ANSWER THESE 13 QUESTIONS**

<b>1. PATIENT LOOKS</b>	<b>Well</b>	<b>Unwell Ill Awful</b>
<b>2. PATIENT APPEARS</b>	<b>Awake and alert</b>	<b>Awake but confused Drowsy Responds to pain only Unwakable</b>
<b>3. TEMPERATURE</b>		<b>.... °Centigrade</b>
<b>4. PULSE (AT REST)</b>		<b>beats/minute</b>
<b>5. BREATHING RATE</b>		<b>breaths/minute</b>
<b>6. BLOOD PRESSURE</b>		<b>.../.... mmHg</b>
<b>7. SKIN COLOUR</b>	<b>Normal</b>	<b>Flushed Blue or cyanosed Pale or anaemic Yellow or jaundiced</b>
<b>8. SKIN TEMPERATURE TO TOUCH</b>	<b>Warm or normal</b>	<b>Hot or fevered Cold and dry Cold and clammy</b>
<b>9. A HEAVING CHEST ON BREATHING</b>	<b>No</b>	<b>Yes</b>
<b>10. PERSPIRATION or SWEATING</b>	<b>No</b>	<b>Yes</b>
<b>11. DEHYDRATION or DRY TONGUE</b>	<b>No</b>	<b>Yes</b>
<b>12. PAIN or DISTRESS ON MOVING</b>	<b>No</b>	<b>Yes</b>
<b>13. PAIN or STIFFNESS IN THE NECK</b>	<b>No</b>	<b>Yes</b>

**THESE BODY DIAGRAMS MAY BE USED FOR ILLUSTRATION IF REQUIRED**

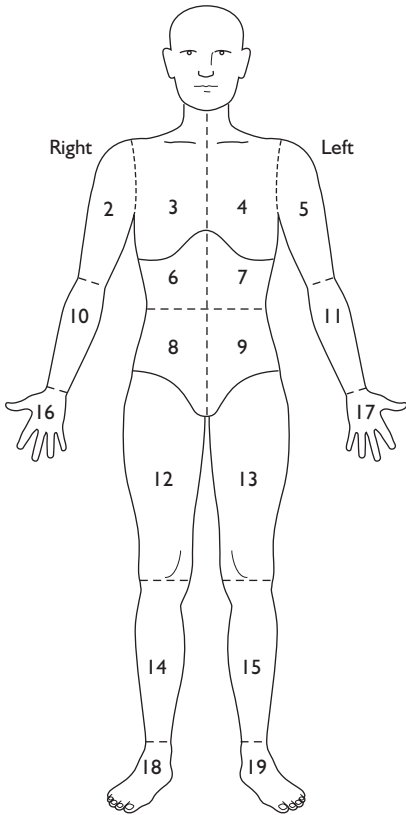


Diagram 3 *Front*

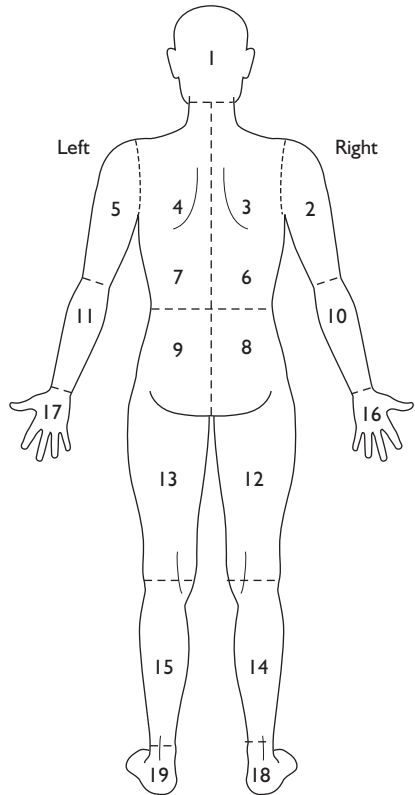


Diagram 4 *Back*

**(O) CHEST (bare all chest, front and back)**

- |  |                |                 |                |
|--|----------------|-----------------|----------------|
| 1. Signs of injury to chest                                      | <b>No</b>      | <b>Yes</b>      |                |
| 2. Tender chest wall   | <b>No</b>      | <b>Yes</b>      |                |
| 3. Position of windpipe in neck                                  | <b>Central</b> | <b>To right</b> | <b>To left</b> |
| 4. Chest movement on breathing                                   | <b>Relaxed</b> | <b>Heaving</b>  |                |
|  |                | <b>Painful</b>  |                |
|  |                | <b>Unequal</b>  |                |
| 5. Air entry of chest (describe the position of any abnormality) | <b>Normal</b>  | <b>Wheezy</b>   |                |
|  |                | <b>Crackly</b>  |                |

**(P) ABDOMEN (ABDO)**

<b>1. Abdo size</b>	<b>Normal</b>	<b>Distended</b>
<b>2. Abdo pain on coughing</b>	<b>No</b>	<b>Yes</b>
<b>3. Abdo pain on moving</b>	<b>No</b>	<b>Yes</b>
<b>4. Abdo pain on puffing out or sucking in tummy wall</b>	<b>No</b>	<b>Yes</b>
<b>5. Areas of tenderness found</b>	<b>No</b>	<b>Yes</b>
<b>6. Any lumps or swellings found</b>	<b>No</b>	<b>Yes</b>
<b>7. Bowel sounds (BS)</b>	<b>Normal BS</b>	<b>Increased BS Tinkling BS No BS heard</b>

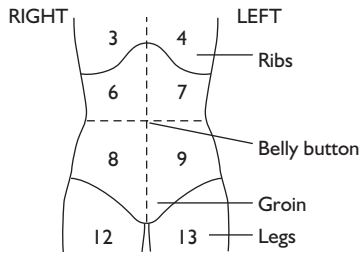


Diagram 5 *Abdomen*

**(Q) GENERAL EXAMINATION**

<b>1. Glands found</b>	<b>No</b>	<b>Yes, neck Tender</b>	<b>R</b>	<b>L</b>
		<b>Yes, armpit Tender</b>	<b>R</b>	<b>L</b>
		<b>Yes, groin Tender</b>	<b>R</b>	<b>L</b>
			<b>Yes</b>	<b>No</b>
<b>2. Ear discharge (If no pass to 4)</b>	<b>No</b>	<b>Yes, from</b>	<b>R</b>	<b>L</b>
<b>3. Colour of ear discharge</b>		Clear		
		Pus		
		Blood		

<b>4. Throat colour</b>	<b>Normal</b>	<b>Red</b>
<b>5. Tonsil size</b>	<b>Normal</b>	<b>Enlarged</b>
<b>6. Skin rash found</b>	<b>No</b>	<b>Yes</b>
7. Size of rash (in cm)		
8. Colour		
9. Surface (to touch)		
10. Where rash found		

**(R) ANY OTHER COMMENTS OR FINDINGS**

**(S) POSSIBLE DIAGNOSIS**

Examiner's signature

Name (printed) and qualifications

Source: Siderfin, C., Maclean, J. and Haston, W. (1995) The Medical Assessment Questionnaire for Radio. *Journal of Telemedicine and Telecare* 1: 57–60.