Measure Yourself Medical Outcome Profile (MYMOP)

Name: _____ ***Date:*** _____

Choose one or two symptoms (physical or mental) which bother you the most. Now consider how severe each symptom has been over the past week and score it by circling the number that most accurately represents your pain.

SYMPTOM 1: _____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

SYMPTOM 2: _____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

Choose one activity (physical, social, or mental) that is important to you, and that your problem makes difficult or prevents you from doing. Score how badly this activity has been affected in the past week due to your problem.

ACTIVITY: _____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

How would you rate your general feeling of well-being suring the past week?

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

How long have you had Symptom 1, either all the time or on and off?

0 - 4 WEEKS 4 - 12 WEEKS 3 MONTHS - 1 YEAR 1 - 5 YEARS OVER 5 YEARS

Are you taking any medication FOR THIS PROBLEM? Please circle: **YES / NO**

IF YES, Please write name of medication and how often it is taken:

_____

How important to you is cutting down this medication?

NOT IMPORTANT A BIT IMPORTANT VERY IMPORTANT NOT APPLICABLE

IF NO, How important to you is avoiding medication for this problem?

NOT IMPORTANT A BIT IMPORTANT VERY IMPORTANT NOT APPLICABLE