

Health Analysis

No. _____ Date _____

Patient _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Marital Status: Single Married Widowed Separated Divorced

Age _____ Occupation _____

PLEASE MARK THE APPROPRIATE ANSWER

- | | | | |
|-----|--|------------------------------|-----------------------------|
| 1. | Do you need glasses to read? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. | Do you need glasses to see things at a distance? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. | Has your eyesight blacked out completely? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. | Do your eyes continually blink or water? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. | Do you often have bad pains in your eyes? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. | Are your eyes often red or inflamed? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. | Are you hard of hearing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. | Have you ever had a fluid leaking from your ear? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. | Do you have constant noises in your ears? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. | Do you have to clear your throat constantly? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. | Do you often feel a choking lump in your throat? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. | Are you often troubled with bad spells of sneezing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. | Is your nose continually stuffed up? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. | Do you suffer from a constantly running nose? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. | Have you at times had bad nose bleeds? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 16. | Do you often catch severe colds? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 17. | Do you frequently suffer from heavy chest colds? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 18. | When you catch a cold, do you always have to go to bed? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 19. | Do frequent colds keep you miserable all winter? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 20. | Do you get hay fever? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 21. | Do you suffer from asthma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 22. | Are you troubled by constant coughing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 23. | Have you ever coughed up blood? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 24. | Do you wake up drenched with sweat during the middle of the night? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 25. | Have you ever had a chronic chest condition? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 26. | Have you ever had T.B. (tuberculosis)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 27. | Did you ever live with anyone who had T.B.? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 28. | Has a doctor ever said your blood pressure was too high? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 29. | Has a doctor ever said your blood pressure was too low? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 30. | Do you have pains in the heart or chest? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 31. | Are you often bothered by thumping of the heart? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 32. | Does your heart often race like mad? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 33. | Do you often have difficulty in breathing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 34. | Do you get out of breath before anyone else? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 35. | Do you sometimes get out of breath just sitting still? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 36. | Are your ankles often badly swollen? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 37. | Do cold hands or feet trouble you, even in hot weather? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 38. | Do you suffer from frequent cramps in your legs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 39. | Has a doctor ever said you had heart trouble? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 40. | Does heart trouble run in your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 41. | Have you lost more than half your teeth? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 42. | Are you troubled by bleeding gums? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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|-----|--|--------------------------|------------|--------------------------|-----------|
| 43. | Have you often had severe toothaches? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 44. | Is your tongue usually badly coated? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 45. | Is your appetite always poor? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 46. | Do you usually eat sweets or other foods between meals? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 47. | Do you always gulp your food hurriedly? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 48. | Do you often suffer from an upset stomach? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 49. | Do you usually feel bloated after eating? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 50. | Do you usually belch a lot after eating? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 51. | Are you often sick at your stomach? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 52. | Do you suffer from indigestion? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 53. | Do severe pains in the stomach often cause you to double over? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 54. | Do you suffer from constant stomach trouble? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 55. | Does stomach trouble run in your family? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 56. | Has a doctor ever said you had stomach ulcers? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 57. | Do you suffer from frequent loose bowel movements? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 58. | Have you ever had severe bloody diarrhea? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 59. | Were you ever troubled with intestinal worms? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 60. | Do you constantly suffer from bad constipation? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 61. | Have you ever had piles (rectal hemorrhoids)? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 62. | Have you ever had jaundice (yellow eyes and skin)? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 63. | Have you ever had serious liver or gall bladder trouble? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 64. | Are your joints often painfully swollen? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 65. | Do your muscles and joints constantly feel stiff? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 66. | Do you usually have severe pains in the arms or legs? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 67. | Are you crippled with severe arthritis? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 68. | Does arthritis run in your family? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 69. | Do weak or painful feet make your life miserable? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 70. | Do pains in the back make it hard for you to keep up with your work? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 71. | Are you troubled with a serious bodily disability or deformity? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 72. | Do you have sensitive skin? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 73. | Does it take a long time for a cut to heal? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 74. | Does your face often get badly flushed? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 75. | Do you sweat a great deal, even in cold weather? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 76. | Are you often bothered by severe itching? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 77. | Does your skin often break out in a rash? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 78. | Are you often troubled with boils? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 79. | Do you suffer from frequent severe headaches? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 80. | Does pressure or pain in the head often make life miserable? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 81. | Are headaches common in your family? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 82. | Do you have hot or cold spells? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 83. | Do you often have spells of severe dizziness? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 84. | Do you frequently feel faint? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 85. | Have you fainted more than twice in your life? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 86. | Do you have constant numbness or tingling in any part of your body? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 87. | Was any part of your body ever paralyzed? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 88. | Were you ever knocked unconscious? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 89. | Have you at times had a twitching of the head, face or shoulders? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 90. | Did you ever have a severe seizure or convulsion (epilepsy)? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 91. | Has anyone in your family ever had a seizure or convulsion (epilepsy)? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 92. | Do you bite your nails? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 93. | Are you troubled by stuttering or stammering? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 94. | Are you a sleepwalker? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 95. | Are you a bed wetter? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| 96. | Were you a bed wetter between the ages of 8 to 14? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

WOMEN ONLY... ARE YOU PREGNANT? **YES** **NO**

- 97w. Have your menstrual periods usually been painful? **YES** **NO**
98w. Have you often felt weak or sick with your periods? **YES** **NO**
99w. Have you often had to lie down when your periods came on? **YES** **NO**
100w. Have you usually been tense or jumpy with your periods? **YES** **NO**
101w. Have you ever had severe hot flashes or sweats? **YES** **NO**
102w. Have you often been troubled with a vaginal discharge? **YES** **NO**

MEN ONLY

- 97m. Have you ever had anything wrong with your genitals? **YES** **NO**
98m. Are your genitals often painful or sore? **YES** **NO**
99m. Have you ever had treatment for your genitals? **YES** **NO**
100m. Has a doctor ever said you had a hernia (rupture)? **YES** **NO**
101m. Have you ever passed blood while urinating? **YES** **NO**
102m. Do you have trouble starting your stream when urinating? **YES** **NO**
103. Do you have to get up every night and urinate? **YES** **NO**
104. During the day, do you usually have to urinate frequently? **YES** **NO**
105. Do you often have severe burning when you urinate? **YES** **NO**
106. Do you sometimes lose control of your bladder? **YES** **NO**
107. Has a doctor ever said you had kidney or bladder disease? **YES** **NO**
108. Are you often exhausted or fatigued? **YES** **NO**
109. Does working tire you out completely? **YES** **NO**
110. Do you usually get up tired or exhausted in the morning? **YES** **NO**
111. Does every little effort wear you out? **YES** **NO**
112. Are you constantly too tired and exhausted to even eat? **YES** **NO**
113. Do you suffer from severe nervous exhaustion? **YES** **NO**
114. Does nervous exhaustion run in your family? **YES** **NO**
115. Are you frequently ill? **YES** **NO**
116. Are you frequently confined to bed by illness? **YES** **NO**
117. Are you always in poor health? **YES** **NO**
118. Are you considered a sickly person? **YES** **NO**
119. Do you come from a sickly family? **YES** **NO**
120. Do severe pains and aches make it impossible to work? **YES** **NO**
121. Do you wear yourself out worrying about work? **YES** **NO**
122. Are you always ill and unhappy? **YES** **NO**
123. Are you constantly made miserable by poor health? **YES** **NO**
124. Did you ever have scarlet fever? **YES** **NO**
125. As a child, did you have rheumatic fever, growing pains, or twitching limbs? **YES** **NO**
126. Did you ever have malaria? **YES** **NO**
127. Were you ever treated for severe anemia? **YES** **NO**
128. Were you ever treated for venereal disease? **YES** **NO**
129. Do you have diabetes? **YES** **NO**
130. Did a doctor ever say you had a goiter in your neck? **YES** **NO**
131. Did a doctor ever treat you for a tumor or cancer? **YES** **NO**
132. Do you suffer from any chronic disease? **YES** **NO**
133. Are you definitely underweight? **YES** **NO**
134. Are you definitely overweight? **YES** **NO**
135. Did a doctor ever say you had varicose veins (swollen veins) in your legs? **YES** **NO**
136. Did you ever have a serious operation? **YES** **NO**
137. Did you ever have a serious injury? **YES** **NO**
138. Do you often have small accidents or injuries? **YES** **NO**
139. Do you usually have difficulty falling or staying asleep? **YES** **NO**
140. Do you find it impossible to take a regular rest period each day? **YES** **NO**
141. Do you find it difficult to exercise daily? **YES** **NO**

142.	Do you smoke more than 20 cigarettes a day?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
143.	Do you drink more than 6 cups of coffee or tea a day?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
144.	Do you usually consume 2 or more alcoholic drinks a day?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
145.	Do you sweat or tremble a lot during examinations or questioning?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
146.	Do you get nervous and shaky when approached by a superior?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
147.	Does your work fall to pieces when a boss or superior is watching you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
148.	Does your thinking get mixed up when you have to do things quickly?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
149.	Must you do things slowly to do them without mistakes?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
150.	Do you always get directions and orders wrong?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
151.	Are you anxious around unfamiliar people or places?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
152.	Are you scared to be alone when there are no friends around you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
153.	Is it difficult to make up your mind?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
154.	Do you always wish you had someone at your side to advise you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
155.	Are you considered a clumsy person?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
156.	Does it bother you to eat anywhere except your home?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
157.	Do you feel alone and sad at a party?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
158.	Do you usually feel unhappy and depressed?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
159.	Do you often cry?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
160.	Are you always miserable and blue?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
161.	Does life look entirely hopeless?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
162.	Do you often wish you were dead and away from it all?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
163.	Does worrying continually get you down?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
164.	Does worrying run in your family?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
165.	Does every little thing get on your nerves and wear you out?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
166.	Are you considered a nervous person?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
167.	Does nervousness run in your family?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
168.	Did you ever have a nervous breakdown?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
169.	Did anyone in your family ever have a nervous breakdown?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
170.	Were you ever a patient in a mental hospital?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
171.	Was anyone in your family ever in a mental hospital?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
172.	Are you extremely shy or sensitive?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
173.	Do you have a shy or sensitive family?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
174.	Are your feelings easily hurt?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
175.	Does criticism always hurt you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
176.	Are you considered a touchy person?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
177.	Do people usually misunderstand you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
178.	Is your guard up, even around your friends?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
179.	Do you always do things on sudden impulse?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
180.	Are you easily upset or irritated?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
181.	Do you go to pieces if you don't constantly control yourself?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
182.	Do little annoyances get on your nerves and get you angry?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
183.	Does it make you angry to have anyone tell you what to do?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
184.	Do people often annoy and irritate you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
185.	Do you often flare up in anger if you can't have what you want right away?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
186.	Do you often get in a violent rage?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
187.	Do you often shake or tremble?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
188.	Are you constantly keyed up or jittery?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
189.	Do sudden noises make you jump or shake?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
190.	Do you tremble or feel weak when someone shouts at you?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
191.	Do you become scared at sudden movements or noises at night?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
192.	Are you awakened out of your sleep by frightening dreams?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
193.	Do frightening thoughts keep coming back in your mind?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
194.	Do you often become frightened for no apparent reason?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
195.	Do you often break out in a cold sweat?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO