HEALTH ANALYSIS

No. _____ Date _____

Patient _____ Home Phone (___)_____

Address _____ City _____ State _____ Zip _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Age _____ Occupation _____

Please Circle the Appropriate Answer.

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

43.	Have you often had severe tooth aches?	Yes	No
44.	Is your tongue usually badly coated?	Yes	No
45.	Is your appetite always poor?	Yes	No
46.	Do you usually eat sweets or other foods between meals?	Yes	No
47.	Do you always gulp your food hurriedly?	Yes	No
48.	Do you often suffer from an upset stomach?	Yes	No
49.	Do you usually feel bloated after eating?	Yes	No
50.	Do you usually belch a lot after eating?	Yes	No
51.	Are you often sick at your stomach?	Yes	No
52.	Do you suffer from indigestion?	Yes	No
53.	Do severe pains in the stomach often cause you to double up?	Yes	No
54.	Do you suffer from constant stomach trouble?	Yes	No
55.	Does stomach trouble run in your family?	Yes	No
56.	Has a doctor ever said you had stomach ulcers?	Yes	No
57.	Do you suffer from frequent loose bowel movements?	Yes	No
58.	Have you ever had severe bloody diarrhea?	Yes	No
59.	Were you ever troubled with intestinal worms?	Yes	No
60.	Do you constantly suffer from bad constipation?	Yes	No
61.	Have you ever had piles (rectal hemorrhoids)?	Yes	No
62.	Have you ever had jaundice (yellow eyes and skin)?	Yes	No
63.	Have you ever had serious liver or gall bladder trouble?	Yes	No
64.	Are your joints often painfully swollen?	Yes	No
65.	Do your muscles and joints constantly feel stiff?	Yes	No
66.	Do you usually have severe pains in the arms or legs?	Yes	No
67.	Are you crippled with severe arthritis?	Yes	No
68.	Does arthritis run in your family?	Yes	No
69.	Do weak or painful feet make your life miserable?	Yes	No
70.	Do pains in the back make it hard for you to keep up with your work?	Yes	No
71.	Are you troubled with a serious bodily disability or deformity?	Yes	No
72.	Do you have sensitive skin?	Yes	No
73.	Does it take a long time for a cut to heal?	Yes	No
74.	Does your face often get badly flushed?	Yes	No
75.	Do you sweat a great deal, even in cold weather?	Yes	No
76.	Are you often bothered by severe itching?	Yes	No
77.	Does your skin often break out in a rash?	Yes	No
78.	Are you often troubled with boils?	Yes	No
79.	Do you suffer from frequent severe headaches?	Yes	No
80.	Does pressure or pain in the head often make life miserable?	Yes	No
81.	Are headaches common in your family?	Yes	No
82.	Do you have hot or cold spells?	Yes	No
83.	Do you often have spells of severe dizziness?	Yes	No
84.	Do you frequently feel faint?	Yes	No
85.	Have you fainted more than twice in your life?	Yes	No
86.	Do you have constant numbness or tingling in any part of your body?	Yes	No
87.	Was any part of your body ever paralyzed?	Yes	No
88.	Were you ever knocked unconscious?	Yes	No
89.	Have you at times had a twitching of the head, face or shoulders?	Yes	No
90.	Did you ever have a seizure or convulsion (epilepsy)?	Yes	No
91.	Has anyone in your family ever had seizures or convulsion (epilepsy)?	Yes	No
92.	Do you bite your nails?	Yes	No
93.	Are you troubled by stuttering or stammering?	Yes	No
94.	Are you a sleep walker?	Yes	No
95.	Are you a bed wetter?	Yes	No
96.	Were you a bed wetter between the ages of 8 to 14?	Yes	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 for you to do your 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 of the 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 under weight?	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 asleep 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? ..... Yes No
143. Do you drink more than six cups of coffee or tea a day? ..... Yes No
144. Do you usually take two or more alcoholic drinks a day? ..... Yes No
145. Do you sweat or tremble a lot during examinations or questioning? ..... Yes No
146. Do you get nervous and shaky when approached by a superior? ..... Yes No
147. Does your work fall to pieces when the boss or a superior is watching you? ..... Yes No
148. Does your thinking get completely mixed up when you have to do things quickly? . Yes No
149. Must you do things slowly to do them without mistakes? ..... Yes No
150. Do you always get directions and orders wrong? ..... Yes No
151. Are you anxious around unfamiliar people or places? ..... Yes No
152. Are you scared to be alone when there are no friends around you? ..... Yes No
153. Is it difficult for you to make up your mind? ..... Yes No
154. Do you always wish you had someone at your side to advise you? ..... Yes No
155. Are you considered a clumsy person? ..... Yes No
156. Does it bother you to eat anywhere except in your home? ..... Yes No

157. Do you feel alone and sad at a party? ..... Yes No
158. Do you usually feel unhappy and depressed? ..... Yes No
159. Do you often cry? ..... Yes No
160. Are you always miserable and blue? ..... Yes No
161. Does life look entirely hopeless? ..... Yes No
162. Do you often wish you were dead and away from it all? ..... Yes No

163. Does worrying continually get you down? ..... Yes No
164. Does worrying run in your family? ..... Yes No
165. Does every little thing get on your nerves and wear you out? ..... Yes No
166. Are you considered a nervous person? ..... Yes No
167. Does nervousness run in your family? ..... Yes No
168. Did you ever have a nervous breakdown? ..... Yes No
169. Did anyone in your family ever have a nervous breakdown? ..... Yes No
170. Were you ever a patient in a mental hospital? ..... Yes No
171. Was anyone in your family ever in a mental hospital? ..... Yes No

172. Are you extremely shy or sensitive? ..... Yes No
173. Do you have a shy or sensitive family? ..... Yes No
174. Are you feeling easily hurt? ..... Yes No
175. Does criticism always hurt you? ..... Yes No
176. Are you considered a touchy person? ..... Yes No
177. Do people usually misunderstand you? ..... Yes No

178. Is your guard up, even around friends? ..... Yes No
179. Do you always do things on sudden impulse? ..... Yes No
180. Are you easily upset or irritated? ..... Yes No
181. Do you go to pieces if you don't constantly control yourself? ..... Yes No
182. Do little annoyances get on your nerves and get you angry? ..... Yes No
183. Does it make you angry to have anyone tell you what to do? ..... Yes No
184. Do people often annoy and irritate you? ..... Yes No
185. Do you often flare up in anger if you can't have what you want right away? ..... Yes No
186. Do you often get in a violent rage? ..... Yes No

187. Do you often shake or tremble? ..... Yes No
188. Are you constantly keyed up or jittery? ..... Yes No
189. Do sudden noises make you jump or shake? ..... Yes No
190. Do you tremble or feel weak whenever someone shouts at you? ..... Yes No
191. Do you become scared at sudden movements or noises at night? ..... Yes No
192. Are you awakened out of your sleep by frightening dreams? ..... Yes No
193. Do frightening thoughts keep coming back in your mind? ..... Yes No
194. Do you often become frightened for no apparent reason? ..... Yes No
195. Do you often break out in a cold sweat? ..... Yes No