

HEALTH APPRAISAL QUESTIONNAIRE

NAME _____

DATE ___/___/___

PART 1

Circle any of the following medications you are currently taking:

- | | | | | | | | |
|-------------------------|-----------------------|----------------------|----------------------|----------------------|---------------------------|----------------|---------------------|
| -antacids | -antidiabetic/insulin | -cortisone | -high blood pressure | -laxatives | -radiation | -ulcer | -recreational drugs |
| -antibiotics/antifungal | -aspirin/Tylenol | -anti-inflammatories | | -lithium | -relaxants/sleeping pills | -other _____ | |
| -antidepressants | -chemotherapy | -heart medications | -hormones | -oral contraceptives | | -thyroid _____ | |

Circle if you eat, drink, or use:

- | | | | |
|-----------------------|------------------|---------------------------|---|
| -alcohol | -coffee | -margarine | -vitamins and or minerals (please list) _____ |
| -candy | -distilled water | -refined sugars | _____ |
| -carbonated beverages | -fried foods | -saccharine (Sweet & Low) | _____ |
| -cigarettes | -luncheon meats | -chewing tobacco | _____ |

Circle if you:

- | | | |
|------------------|-----------------------------|-----------------------------------|
| -diet often | -salt food without tasting | -are exposed to chemicals at work |
| -do not exercise | -are under excessive stress | -are exposed to cigarette smoke |

Part 2

Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.

0=symptom not present 1=mild 2=moderate 3=severe

SECTION A:					SECTION C:						
1.	Burping	0	1	2	3	1.	Stomach pains	0	1	2	3
2.	Fullness for extended time after meals	0	1	2	3	2.	Stomach pains just before/after meals	0	1	2	3
3.	Bloating	0	1	2	3	3.	Dependency on antacids	0	1	2	3
4.	Poor appetite	0	1	2	3	4.	Chronic abdominal pain	0	1	2	3
5.	Stomach upsets easily	0	1	2	3	5.	Butterfly sensations in stomach	0	1	2	3
6.	History of constipation	0	1	2	3	6.	Difficulty belching	0	1	2	3
7.	Known food allergies	0	1	2	3	7.	Stomach pain when emotionally upset	0	1	2	3
SECTION B:					SECTION D:						
1.	Abdominal cramps	0	1	2	3	8.	Sudden, acute indigestion	0	1	2	3
2.	Indigestion 1-3 hours after eating	0	1	2	3	9.	Relief of symptoms by carbonation	0	1	2	3
3.	Fatigue after eating	0	1	2	3	10.	Relief of symptoms with cream/milk	0	1	2	3
4.	Lower-bowel gas	0	1	2	3	11.	History of ulcers or gastritis	0	1	2	3
5.	Alternating constipation & diarrhea	0	1	2	3	12.	Current ulcer	0	1	2	3
6.	Diarrhea	0	1	2	3	13.	Black stool when not taking iron	0	1	2	3
7.	Roughage & fiber causes constipation	0	1	2	3	1.	Seasonal diarrhea	0	1	2	3
8.	Mucous in stools	0	1	2	3	2.	Frequent and current infections/colds	0	1	2	3
9.	Stool poorly formed	0	1	2	3	3.	Bladder and kidney infections	0	1	2	3
10.	Shiny stool	0	1	2	3	4.	Vaginal yeast infections	0	1	2	3
11.	Three + large bowel movements daily	0	1	2	3	5.	Abdominal cramps	0	1	2	3
12.	Foul smelling stool	0	1	2	3	6.	Toe and fingernail fungus	0	1	2	3
13.	Dry skin and/or brittle hair	0	1	2	3	7.	Alternating constipation & diarrhea	0	1	2	3
14.	Pain in left side under rib cage	0	1	2	3	8.	Constipation	0	1	2	3
15.	Acne	0	1	2	3	9.	History of antibiotic use	0	1	2	3
16.	Food allergies	0	1	2	3	10.	Meat eater	0	1	2	3
						11.	Rapidly failing vision	0	1	2	3

Part 3

Continue through Parts 3-13. Some questions are repeated. Answer each question.

Females: Skip Part 9 **Males:** Skip Part 10

SECTION A:					(Part 3 Continued)						
1.	Intolerance to greasy foods	0	1	2	3	17.	Big toe painful	0	1	2	3
2.	Headaches after eating	0	1	2	3	18.	Pain radiates along outside of leg	0	1	2	3
3.	Light-colored stool	0	1	2	3	19.	Dry skin/hair	0	1	2	3
4.	Foul-smelling stool	0	1	2	3	20.	Red blood in stool	0	1	2	3
5.	Less than one bowel movement daily	0	1	2	3	21.	Have had jaundice or hepatitis	0	1	2	3
6.	Constipation	0	1	2	3	22.	High blood pressure/low HDL cholesterol	0	1	2	3
7.	Hard stool	0	1	2	3	23.	Cholesterol level above 215	0	1	2	3
8.	Sour taste in mouth	0	1	2	3	24.	Triglyceride level above 115	0	1	2	3
9.	Grey-colored skin	0	1	2	3	SECTION B:					
10.	Yellow in whites of eyes	0	1	2	3	1.	Swollen eyes	0	1	2	3
11.	Bad breath	0	1	2	3	2.	Strong-smelling urine	0	1	2	3
12.	Body odor	0	1	2	3	3.	Thick skin & fingernails	0	1	2	3
13.	Fatigue and sleepiness after eating	0	1	2	3	4.	Dry skin	0	1	2	3
14.	Pain in right side under rib cage	0	1	2	3	5.	Sensitive to the cold	0	1	2	3
15.	Painful to pass stool	0	1	2	3	6.	Cold hands and feet	0	1	2	3
16.	Retain water	0	1	2	3						

(Part 3 continued)															
7.	Excessive menstrual bleeding	0	1	2	3					15.	Constipation	0	1	2	3
8.	Chronic fatigue	0	1	2	3					16.	Thinning/loss of outer part of eyebrow	0	1	2	3
9.	Trouble waking up in the morning	0	1	2	3					17.	Gain weight easily	0	1	2	3
10.	Depressed apathetic	0	1	2	3					18.	Anemia unaffected by iron	0	1	2	3
11.	Low sex drive	0	1	2	3					19.	Armpit temperature below 97.6°F	0	1	2	3
12.	Puffy or wrinkly skin	0	1	2	3					20.	Slow reflexes	0	1	2	3
13.	Irritability caused by sugar	0	1	2	3					21.	Infertility	0	1	2	3
14.	Premenstrual tension	0	1	2	3										

Part 4

SECTION A:

1.	Sensitive to exhaust, smoke, smog	0	1	2	3
2.	Periodic constipation	0	1	2	3
3.	Intolerant of exercise	0	1	2	3
4.	Depression or rapid mood swings	0	1	2	3
5.	Dark circles under eyes	0	1	2	3
6.	Dizziness upon standing	0	1	2	3
7.	Lack of mental alertness	0	1	2	3
8.	Catch colds when weather changes	0	1	2	3
9.	Difficulty breathing	0	1	2	3
10.	Water retention	0	1	2	3
11.	Eyes sensitive to bright light	0	1	2	3
12.	Feel weak & shaky	0	1	2	3

SECTION B:

1.	Inflamed or bleeding gums	0	1	2	3
2.	Runny nose	0	1	2	3
3.	Get boils or styes	0	1	2	3
4.	Nose bleeds	0	1	2	3
5.	Loss of smell	0	1	2	3
6.	Throat infections	0	1	2	3
7.	Cold sores/fever blisters	0	1	2	3
8.	Loss of taste	0	1	2	3
9.	Poor wound healing	0	1	2	3
10.	Hair falls out	0	1	2	3
11.	Swollen lymph glands	0	1	2	3
12.	Ear infections	0	1	2	3
13.	Hair grows slowly	0	1	2	3
14.	Slow to recover from cold or flu	0	1	2	3
15.	Catch colds or flu easily	0	1	2	3
16.	Bumpy skin on backs of arms	0	1	2	3

SECTION C:

1.	Eczema and psoriasis	0	1	2	3
2.	Asthma/bronchitis	0	1	2	3
3.	Migraine headaches	0	1	2	3
4.	Entire body aches, painful to touch	0	1	2	3
5.	Swollen joints	0	1	2	3
6.	Food sensitivities or allergies	0	1	2	3
7.	Feel sick, depressed from certain foods	0	1	2	3
8.	Chronic pain	0	1	2	3
9.	Painful stomach/intestines	0	1	2	3
10.	Alternating constipation & diarrhea	0	1	2	3
11.	Mucous in throat	0	1	2	3
12.	Post-nasal drip	0	1	2	3
13.	Discharge from eyes	0	1	2	3
14.	Itchy eyes	0	1	2	3
15.	Puffiness/dark circles under eyes	0	1	2	3
16.	Ear discharge or stuffy ears	0	1	2	3
17.	Sinusitis or rhinitis	0	1	2	3
18.	Runny nose	0	1	2	3
19.	Breathe through mouth	0	1	2	3
20.	Swollen tongue	0	1	2	3
21.	Difficulty swallowing	0	1	2	3
22.	Bedwetting	0	1	2	3
23.	Hyperactivity	0	1	2	3
24.	Chronic lung congestion	No	Yes		
25.	Use aspirin or Tylenol regularly	No	Yes		
26.	Use cortisone or prednisone	No	Yes		
27.	Total hair loss (Alopecia)	No	Yes		

Part 5

SECTION A:

1.	Shortness of breath	0	1	2	3
2.	Chest pain while walking	0	1	2	3
3.	Heaviness in legs	0	1	2	3
4.	Calf muscles cramp while walking	0	1	2	3
5.	Heart pounds easily	0	1	2	3
6.	Feel jittery	0	1	2	3
7.	Heart misses beats or has extra beats	0	1	2	3
8.	Swelling of feet and ankles	0	1	2	3
9.	Rapidly beating heart	0	1	2	3
10.	Heartburn after eating	0	1	2	3
11.	Pain in left arm	0	1	2	3
12.	Exhausted after minor exertion	0	1	2	3
13.	Do you do aerobic exercise?	No	Yes		
14.	Have you ever exercised regularly?	No	Yes		
15.	Bright red nose	No	Yes		
16.	At rest, heart beats per minute (leave blank if under 80 BPM)	80-90	90+		

SECTION B:

1.	Cold hands and feet	0	1	2	3
2.	Slurred speech	0	1	2	3
3.	Calf muscles cramp while walking	0	1	2	3
4.	Headaches	0	1	2	3
5.	Numbness in extremities	0	1	2	3
6.	Poor concentration	0	1	2	3
7.	ringing in ears	0	1	2	3
8.	Ear canal hair	No	Yes		
9.	Heart attack	No	Yes		
10.	Stroke	No	Yes		
11.	Vertical wrinkle in lower ear lobe	No	Yes		

SECTION C:

1.	Pain in morning in back of head/neck	0	1	2	3
2.	Dizziness	0	1	2	3
3.	Vertigo	0	1	2	3
4.	Fatigue easily	0	1	2	3
5.	Blushing with no apparent cause	0	1	2	3
6.	Is your blood pressure high?	No	Yes		

Part 6

SECTION A:

1.	Dizziness when standing suddenly	0	1	2	3
2.	Loss of vision when standing suddenly	0	1	2	3
3.	Crave sweets	0	1	2	3
4.	Headaches eased by sweets/alcohol	0	1	2	3
5.	Feel shaky	0	1	2	3
6.	Irritable if a meal is missed	0	1	2	3

7.	Wake up in night craving sweets	0	1	2	3
8.	Feel tired or weak if a meal is missed	0	1	2	3
9.	Heart palpitations after eating sweets	0	1	2	3
10.	Need to drink coffee to get started	0	1	2	3
11.	Impatient, moody, nervous	0	1	2	3
12.	Feel tired 1-3 hours after eating	0	1	2	3

(Part 6 Continued)												
13.	Poor memory	0	1	2	3		5.	Boils and leg sores	0	1	2	3
14.	Poor concentration	0	1	2	3		6.	Lesions/cuts that take a long time to heal	0	1	2	3
15.	Forgetful	0	1	2	3		7.	Overweight	0	1	2	3
16.	Calmer after eating	No	Yes				8.	Feel pick-up from exercise	0	1	2	3
SECTION B:							9.	Failing eyesight	0	1	2	3
1.	Night sweats	0	1	2	3		10.	Crave sweets, but eating sweets does not relieve craving	0	1	2	3
2.	Increased thirst	0	1	2	3		11.	Family history of diabetes	0	1	2	3
3.	Lowered resistance to infection	0	1	2	3		12.	Sugar in urine	0	1	2	3
4.	Fatigue	0	1	2	3							
Part 7												
1.	Chest pain	0	1	2	3		9.	Sensitive to smog	0	1	2	3
2.	Chronic cough	0	1	2	3		10.	Infections settle in lungs	0	1	2	3
3.	Difficulty breathing	0	1	2	3		11.	Work around people who smoke	0	1	2	3
4.	Coughing up blood	0	1	2	3		12.	Bronchitis	0	1	2	3
5.	Coughing up phlegm	0	1	2	3		13.	Exposed to chemicals & radiation	No	Yes		
6.	Pain around ribs	0	1	2	3		14.	Do you smoke?	No	Yes		
7.	Shortness of breath	0	1	2	3			What do you smoke?				
8.	Rattling mucous when you breathe	0	1	2	3			Amount per day				
Part 8												
1.	Frequent urination	0	1	2	3		10.	Cloudy urine	0	1	2	3
2.	Frequent bladder infections	0	1	2	3		11.	Strong-smelling urine	0	1	2	3
3.	Rarely need to urinate	0	1	2	3		12.	Back or leg pains associated with dripping after urination	0	1	2	3
4.	Urination when you cough or sneeze	0	1	2	3		13.	History of bladder infections	No	Yes		
5.	Painful/burns when you urinate	0	1	2	3		14.	Have used antibiotics to control urinary tract infections	No	Yes		
6.	Difficulty passing urine	0	1	2	3			If yes, when were they last used?				
7.	Dripping after urination	0	1	2	3			Treatment duration				
8.	Can't hold urine	0	1	2	3							
9.	Rose-colored/bloody urine	0	1	2	3							
Part 9 (MALES ONLY)												
SECTION A:												
1.	Difficulty urinating	0	1	2	3		2.	Anxiety/fear of sexual intimacy	0	1	2	3
2.	A sense of bladder fullness	0	1	2	3		3.	Premature ejaculation	0	1	2	3
3.	Increasing straining with smaller and smaller amounts of urine passing	0	1	2	3		4.	Pain/coldness in genital area	0	1	2	3
4.	Rose-colored/bloody urine	0	1	2	3		5.	Infertile	No	Yes		
5.	Painful/burns when you urinate	0	1	2	3		6.	Varicose veins on scrotum	No	Yes		
6.	Wakr up to urinate at night	0	1	2	3		7.	Low sperm count	No	Yes		
7.	Dripping after urination	0	1	2	3		SECTION C:					
8.	Pain or fatigue in legs or back	0	1	2	3		1.	Discharge from penis	0	1	2	3
9.	Lack of sex drive	0	1	2	3		2.	Past or present rash on penis	0	1	2	3
10.	Painful ejaculation	0	1	2	3		3.	Swollen genitals	0	1	2	3
SECTION B:							4.	Swelling in groin	0	1	2	3
1.	Difficulty attaining/maintaining an erection	0	1	2	3		5.	Venereal disease (gonorrhea, syphilis, Herpes, or other)	No	Yes		
								Have now? _____ Have had in past? _____				
Part 10 (FEMALES ONLY)												
Section A: Circle if you experience any of these symptoms within approximately two weeks (ovulation) prior to menstruation (this section only)							3.	Little or no desire for sex	0	1	2	3
1.	Monthly weight gain	0	1	2	3		4.	Dislike for intercourse	0	1	2	3
3.	Moodiness/ irritability	0	1	2	3		5.	Missed periods	No	Yes		
4.	Bloating and swelling	0	1	2	3		6.	Over 15 years of age and have not begun menstruation	No	Yes		
5.	Nausea/ vomiting	0	1	2	3		7.	Unable to get pregnant	No	Yes		
6.	Suicidal feeling	0	1	2	3		8.	Miscarriages	No	Yes	(_____)	
7.	Anxiety	0	1	2	3		9.	Abortions	No	Yes	(_____)	
8.	Leg cramps and tenderness	0	1	2	3		SECTION C:					
9.	Asthma attacks	0	1	2	3		Check if you experience any of these symptoms during menstruation (This section only)					
10.	Headaches	0	1	2	3		1.	Low abdominal pain	0	1	2	3
11.	Easily distracted	0	1	2	3		2.	Dull ache radiating to low back/ legs	0	1	2	3
12.	Anger	0	1	2	3		3.	Increased urinary frequency	0	1	2	3
13.	Tender breasts	0	1	2	3		4.	Pelvic soreness	0	1	2	3
14.	Lower-back aches	0	1	2	3		5.	Diarrhea	0	1	2	3
15.	Other _____						6.	Headaches	0	1	2	3
SECTION B:							7.	Abdominal bloating	0	1	2	3
1.	Vaginal itching	0	1	2	3		8.	Menstrual pain	0	1	2	3
2.	Vaginal discharge	0	1	2	3		9.	Nausea/ vomiting	0	1	2	3

(Part 10 continued)												
10.	Have to lie down first day or two	0	1	2	3		11.	Premenstrual breast pain/discomfort	0	1	2	3
11.	Craving for sweets	0	1	2	3		12.	Mother used DES while pregnant	No	Yes		
12.	Insomnia	0	1	2	3		13.	Recent pap smear positive	No	Yes		
13.	Light scanty blood flow	0	1	2	3		14.	Family history of breast cancer	No	Yes		
14.	Pain and cramps without blood flow	0	1	2	3		15.	Form of birth control: _____ None _____ Pill _____ IUD _____ _____ Sponge _____ Diaphragm _____ Foam _____ Other _____				
15.	Heavy menstrual bleeding	0	1	2	3		SECTION E:					
16.	Anxiety about menstrual cycle	0	1	2	3		1.	Hot flashes	0	1	2	3
17.	Menstrual pain is getting worse with time	0	1	2	3		2.	Night sweats	0	1	2	3
SECTION D:							3.	Hysterectomy	No	Yes		
1.	Vaginal bumps and sores	0	1	2	3		4.	Depression/mood swings	0	1	2	3
2.	Pubic area sore	0	1	2	3		5.	Insomnia	0	1	2	3
3.	Ovarian cysts	0	1	2	3		6.	Craving for sweets	0	1	2	3
4.	Uterine cysts	0	1	2	3		7.	Heavy bleeding two weeks/month	0	1	2	3
5.	Pain in ovaries	0	1	2	3		8.	Sweating throughout day	0	1	2	3
6.	Breast lumps	0	1	2	3		9.	Dry skin, hair, and vagina	0	1	2	3
7.	Breasts sore to touch	0	1	2	3		10.	Painful intercourse	0	1	2	3
8.	Breasts painful	0	1	2	3		11.	Vaginal pain	0	1	2	3
9.	Water retention	0	1	2	3		12.	Vaginal itching	0	1	2	3
10.	Swollen feeling	0	1	2	3		13.	Osteoporosis (bone loss)	No	Yes		

Part 11												
Section A:												
1.	Pain in fingers	0	1	2	3		3.	Muscle cramps	0	1	2	3
2.	Bones sore/painful	0	1	2	3		4.	Pain in arms and hands	0	1	2	3
3.	Eat meat	0	1	2	3		5.	Leg cramps at night	0	1	2	3
4.	Cavities	0	1	2	3		6.	Stiff all over	0	1	2	3
5.	Arthritis	0	1	2	3		7.	Stiff in morning	0	1	2	3
6.	Drink carbonated beverages	No	Yes	(oz/wk _____)			8.	Unable to sit straight	0	1	2	3
7.	Gum disease	No	Yes				9.	Pain in neck and shoulders	0	1	2	3
8.	Bone loss	No	Yes				SECTION C:					
9.	Calcium deposits	No	Yes				1.	Overflexible joints (double-jointed)	0	1	2	3
10.	Use antacids	No	Yes				2.	Back pain	0	1	2	3
11.	Dentures	No	Yes				3.	Swollen knees/elbows	0	1	2	3
12.	Bone deformity	No	Yes				4.	Athletic injury	0	1	2	3
13.	Osteoporosis/ osteomalacia	No	Yes				5.	Bursitis	0	1	2	3
14.	Recent bone fracture	No	Yes				6.	Tendonitis	0	1	2	3
15.	Post-menopausal	No	Yes				7.	Joint pain	0	1	2	3
SECTION B:							8.	Slipped disc	No	Yes		
1.	Muscle spasms	0	1	2	3		9.	Herniated disc	No	Yes		
2.	Tightness in shoulder muscles	0	1	2	3		10.	Loss in height	No	Yes		
							11.	Injure easily	No	Yes		

Part 12												
1.	Head feels heavy	0	1	2	3		10.	Loss of grip strength	0	1	2	3
2.	Light-headedness/fainting	0	1	2	3		11.	Tingling pain sensation	0	1	2	3
3.	Loss of balance	0	1	2	3		12.	Convulsions	0	1	2	3
4.	Dizziness	0	1	2	3		13.	Incoordination	0	1	2	3
5.	Ringling/buzzing in ears	0	1	2	3		14.	Nervousness	0	1	2	3
6.	Trembling hands	0	1	2	3		15.	Accident prone	0	1	2	3
7.	Loss of feeling in hands/feet	0	1	2	3		16.	Loss of muscle tone	0	1	2	3
8.	Exhaustion after slightest effort	0	1	2	3		17.	Need to sleep 10-12 hours	0	1	2	3
9.	Limbs feel too heavy to hold up	0	1	2	3		18.	Have had shingles	0	1	2	3

PART 13												
1.	Nightmares	0	1	2	3		6.	Awake frequently throughout night	No	Yes		
2.	Can't fall asleep	0	1	2	3		7.	Wake up during night, can't fall back				
3.	Intense dreams	0	1	2	3			Asleep	No	Yes		
4.	Leg cramps/restless legs at night	0	1	2	3		8.	Sleep walk	No	Yes		
5.	Restless, uneasy sleep	0	1	2	3							

Do you have any other symptoms that have not been covered in this questionnaire?												

