

Health Analysis

No. _____

Date _____

Patient _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Marital Status: Single Married Widowed Separated Divorced

Age _____ Occupation _____

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 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 sometimes 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

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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 |

142. Do you smoke more than 20 cigarettes a day? YES NO
143. Do you drink more than 6 cups of coffee or tea a day? YES NO
144. Do you usually consume 2 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 a boss or superior is watching you? YES NO
148. Does your thinking get 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 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 your home? YES NO
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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
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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
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172. Are you extremely shy or sensitive? YES NO
173. Do you have a shy or sensitive family? YES NO
174. Are your feelings 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
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178. Is your guard up, even around your 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
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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 when 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