

**For Office Use Only:**

- Bloomington Natural Care Center
- Burnsville Natural Care Center
- Woodwinds Natural Care Center
- Edith Davis Teaching Clinic
- University Health Service

Date: \_\_\_\_\_

Account Number: \_\_\_\_\_

Your Name: \_\_\_\_\_  
(Last, First, Middle Initial)

Primary Healthcare Provider and/or Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Your answers to the following questions will help us learn more about you and your health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your chief complaint today? \_\_\_\_\_

Check all that apply.

- 1 .....Neck / Back / Joint pain
- 2 .....Headaches
- 3 .....Depression / Anxiety
- 4 .....Respiratory Problems (e.g., asthma, allergies, sinus congestion)
- 5 .....Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)
- 6 .....Urinary Problems (e.g., difficult or painful urination, kidney stones)
- 7 .....Fatigue or low energy
- 8 .....Female reproductive health (e.g., PMS, menopause, infertility)
- 9 .....Male reproductive health (e.g., enlarged prostate, erectile dysfunction)
- 10 .....Stress management
- 11 .....General wellness
- 12 .....Other: \_\_\_\_\_

Please mark on the body forms with an "X" where you are experiencing any pain or other discomfort. Next to the "X", use the symbols to indicate the **type of pain** you have experienced in the past week.

NUMBNESS  
=====

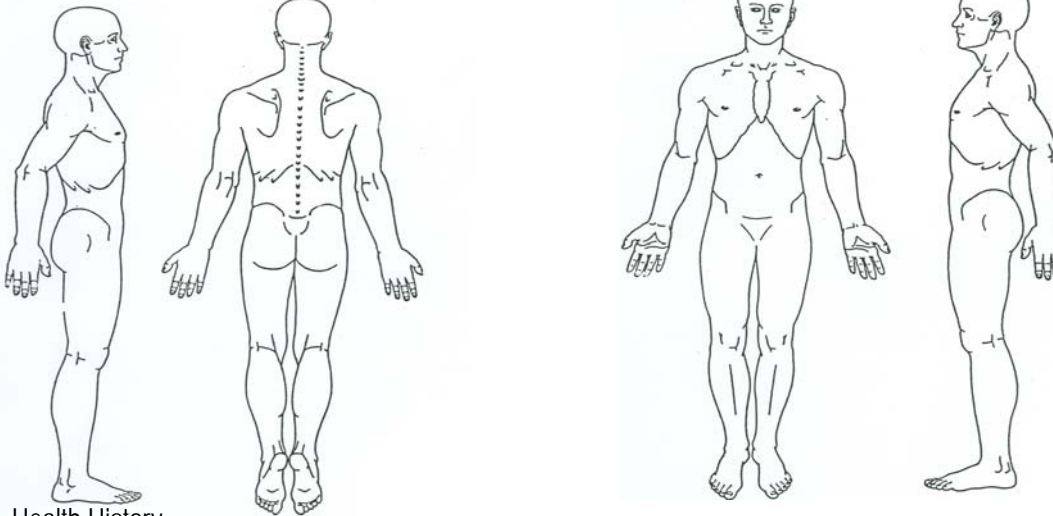
PINS AND NEEDLES  
00000

BURNING  
XXXXX

STABBING  
/////

ACHING  
+++++

OTHER  
\*\*\*\*\*



## 2. Health History

Please list any health problems you currently have or have had. Answer to the best of your knowledge.

Cancer (malignant or metastatic):

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Diabetes (Type I or II):

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Infectious Diseases (e.g. hepatitis, HIV):

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Heart, Lungs and Circulation (e.g. asthma, high blood pressure, previous heart attack):

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Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea):

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Psychosocial Health (e.g. depression, anxiety, violence toward self or others):

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Skeleton and joints (e.g. arthritis, back or neck pain):

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Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases):

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Nervous System (e.g. headache, dizziness, multiple sclerosis, Parkinson's disease):

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Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ringing in ears, severe dental problems):

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Skin (e.g. rashes, sores, moles that have changed):

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Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis):

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Men's Health problems (e.g. enlarged prostate, erectile dysfunction):

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Women's Health problems (e.g. dysmenorrheal, pelvic inflammatory disease, uterine fibroids):

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Other: \_\_\_\_\_

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## Family health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

No

Yes → Please describe your relation to this individual and their condition

Please list any allergies:

Please list any surgeries you have had in the past, and their date:

Please list any traumas or injuries:

Please list:

Current Medications	Dose	Purpose	Prescribed by:

How many children do you have? \_\_\_\_\_

Females only, please list:

Number of pregnancies \_\_\_\_\_

Number of births \_\_\_\_\_

Have you had preventive health screenings for the following (check all that apply):

- blood pressure within the last  month  6 months  year  5 years  5+ years  Never
- breast exam within the last  month  6 months  year  5 years  5+ years  Never
- Pap smear within the last  month  6 months  year  5 years  5+ years  Never
- prostate exam within the last  month  6 months  year  5 years  5+ years  Never
- colonoscopy within the last  month  6 months  year  5 years  5+ years  Never
- fasting blood glucose within the last  month  6 months  year  5 years  5+ years  Never
- cholesterol within the last  month  6 months  year  5 years  5+ years  Never
- blood lipids within the last  month  6 months  year  5 years  5+ years  Never
- dental within the last  month  6 months  year  5 years  5+ years  Never

3. How often do you typically consume alcoholic drinks (e.g. beer, wine)?

- every day
- some days
- not at all

4. How often do you typically consume caffeinated drinks (e.g. coffee, soda)?

- every day
- some days
- not at all

5. Do you use tobacco products (e.g. cigarettes, chewing tobacco, pipe)?

- Yes, currently
- Yes, in the past (Year quit \_\_\_\_\_)
- No, never

6. On average, how much physical activity, exercise, or sports activities have you taken part in during the past month?
- None     Less than 1 time/week     1 time/week     2 -3 times/week     4 or more times/week

Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social and spiritual condition over the past month. Mark the line below with an **X** at the point that summarizes your overall sense of well-being for the past month.

Worst you have  
ever been

Best you have  
ever been

7. What is your marital status? (Please check most current status)

- <sub>1</sub> .....Married or living with significant other  
<sub>2</sub> .....Divorced/Separated  
<sub>3</sub> .....Widowed  
<sub>4</sub> .....Never been married

8. How much schooling have you completed? (Please check one)

- <sub>1</sub> .....Completed less than high school  
<sub>2</sub> .....Graduated from High School  
<sub>3</sub> .....Completed 1-3 years of college  
<sub>4</sub> .....Graduated from a 2-year Associate degree program or technical school  
<sub>5</sub> .....Graduated from college  
<sub>6</sub> .....Completed post-graduate or professional program

9. Please identify your race, as defined by the federal government. (Please check one)

- <sub>1</sub> .....Asian or Pacific Islander  
<sub>2</sub> .....Black/African American  
<sub>3</sub> .....Hispanic  
<sub>4</sub> .....American Indian or Alaskan Native  
<sub>5</sub> .....White  
<sub>6</sub> .....Other \_\_\_\_\_



# Naturopathic Adult Health Assessment

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

Please check any medical treatments you may have used:

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Herbal Medicine	<input type="checkbox"/> Mind/Body Therapies	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Counseling	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Naturopathy	<input type="checkbox"/> Therapeutic Massage
<input type="checkbox"/> Other treatments you have received: _____				

Living Situation: Married Single Divorced Widowed Children (number): \_\_\_\_\_ Children's Ages: \_\_\_\_\_

Prefer relations with:  Male  Female  Male and female

### PRIMARY HEALTH CONCERNS:

In your opinion, what are your most important health concerns?

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____
Others: _____	

Is there any condition, trauma, or incident after which you have never been totally well again? \_\_\_\_\_

On a scale of 1 – 10, how would you rate your current overall state of health? \_\_\_\_\_

Over the past year has your state of health:  Improved  Worsened  Stayed the Same

Blood Type: A B AB O (+) (-) Unsure?

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Wt at 20 yr: \_\_\_\_\_

Over the past year have you gained weight:  Yes (amount): \_\_\_\_\_  No

Have you ever been exposed to toxic chemicals, solvents or other possible toxins?  Yes  No If Yes, please explain:

What are your current health goals? \_\_\_\_\_

**HEALTH HISTORY – ADULTHOOD:**

Please indicate whether you or an immediate relative has ever had the following diseases or conditions:

Disease	Self	Age at onset	Which Relative? (indicate if deceased-D)
Angina/MI/Heart Attack			
High Blood Pressure			
Stroke			
Blood Clot			
High Cholesterol			
Obesity			
Thyroid Disorder			
Diabetes			
Ulcer, GI Bleeding			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Celiac Disease			
Heartburn/Reflux			
Asthma			
Hay Fever/Allergies			
Tuberculosis			
Emphysema			
Pneumonia			
Eczema			
Psoriasis			
Liver Disease/Hepatitis			
Substance Addiction			
Other			

Disease	Self	Age at onset	Which Relative? (indicate if deceased-D)
Epilepsy/Seizures			
Alzheimer’s Disease			
Parkinson’s			
Back problems/sciatica			
Headache			
Anemia			
Mononucleosis			
Depression			
Chronic Fatigue			
Fibromyalgia			
Nervous Exhaustion			
Glaucoma			
Macular Degeneration			
Night Blindness			
Arthritis/Rheumatism			
Cancer Specify: _____			
Kidney, Bladder			
Osteoporosis			
Gout			
Injury (serious)			
Venereal Disease (STDs) Specify _____			
AIDS			

**HEALTH MAINTENANCE:** Please list any significant findings and the date of your last visit for the following exams:

Significant Findings	Date of Last Visit
Routine Exam_____	_____
Pap/Pelvic_____	_____
Breast/Mammogram_____	_____
Prostate Exam_____	_____
Hemocult_____	_____
Flexible Sigmoidoscopy_____	_____
Retinal Eye Exam_____	_____
Dental Exam_____	_____
Describe any dental work done: _____	
Describe oral Hygiene practice: _____	

**HEALTH HISTORY – CHILDHOOD** (check all that apply):

<input type="checkbox"/> Measles	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Strep/Tonsillitis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Polio	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Rubella	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Other: _____				

At the time of your birth, did you experience any unusual birth trauma:  Yes  No

**PSYCHOLOGICAL:**

How would you rate your overall level of stress (with 1 being No Stress, and 10 being Unbearable Stress)?

- 1     2     3     4     5     6     7     8     9     10

What types of things cause you stress? \_\_\_\_\_

What symptoms of stress have you experienced? \_\_\_\_\_

Please list any significant stressors you have experienced (e.g., accidents, divorce, death, change or loss of job, or ending of relationship):

Type of stressor: _____	Month/Year: _____
_____	_____
_____	_____

Do you follow any spiritual practices?  Yes  No    If Yes, what are they? \_\_\_\_\_

Do you practice any form of meditation or relaxation techniques?  Yes  No    If Yes, what types and how often? \_\_\_\_\_

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How would you describe your sleep patterns?

- Normal       Irregular       Heavy       Light       Dream-filled

How do you characterize your relationships (spouses/partners, family, friends, co-workers, etc)? \_\_\_\_\_

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Have you ever been diagnosed with a psychiatric condition?  Yes  No    If Yes, when and how were you treated?

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Name: \_\_\_\_\_

Dates: \_\_\_\_\_

**Food Plan Instructions:**

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food is eaten (“white bread” or “whole wheat bread”), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals do you generally eat each day? One Two Three More than three

How often do you skip meals? Never Once or twice a month Once a week More than once a week

Where do you usually buy your food? \_\_\_\_\_

Who cooks the food you eat? \_\_\_\_\_

List the foods you exclude from your diet and why: \_\_\_\_\_

List any foods you crave, regardless of their nutritional value: \_\_\_\_\_

List any foods to which you are allergic to or have a bad reaction to and how you react: \_\_\_\_\_

Are you thirsty?  No  Yes Amount of plain water you drink each day \_\_\_\_\_

What type of water do you drink? Distilled water Filtered Spring Well Deionized Tap

At what temperature do you prefer to drink liquids?  Hot  Cold  Room temp

# Health Appraisal Questionnaire

Instructions: 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 is not present      1 = Mild      2 = Moderate      3 = Severe

## PART 1

### SECTION A:

1. Burping.....0 1 2 3
2. Fullness for extended time after meals.....0 1 2 3
3. Bloating.....0 1 2 3
4. Poor appetite.....0 1 2 3
5. Stomach.....0 1 2 3
6. History of constipation.....0 1 2 3
7. Known food allergies.....0 1 2 3

### SECTION B:

1. Abdominal cramps.....0 1 2 3
2. Indigestion 1-3 hours after eating.....0 1 2 3
3. Fatigue after eating.....0 1 2 3
4. Lower bowel gas.....0 1 2 3
5. Alternating constipation and diarrhea.....0 1 2 3
6. Diarrhea.....0 1 2 3
7. Roughage and fiber causes constipation.....0 1 2 3
8. Mucous in stools.....0 1 2 3
9. Stool poorly formed.....0 1 2 3
10. Shiny stool.....0 1 2 3
11. Three or more large bowel movements daily.....0 1 2 3
12. Foul smelling stool.....0 1 2 3
13. Dry, flaky skin and/or brittle hair.....0 1 2 3
14. Pain in left side under rib cage.....0 1 2 3
15. Acne.....0 1 2 3
16. Food allergies.....0 1 2 3
17. Difficulty gaining weight.....0 1 2 3

### SECTION C:

1. Stomach pains.....0 1 2 3
2. Stomach pains just before and/or after meals.....0 1 2 3
3. Dependency on antacids.....0 1 2 3
4. Chronic abdominal pain.....0 1 2 3
5. Butterfly sensations in stomach.....0 1 2 3
6. Difficulty belching.....0 1 2 3
7. Stomach pain when emotionally upset.....0 1 2 3
8. Sudden, acute indigestion.....NO YES
9. Relief of symptoms by carbonated beverages.....NO YES
10. Relief of stomach pain by drinking cream/milk.....NO YES
11. History of ulcer or gastritis.....NO YES
12. Current ulcer.....NO YES (10)
13. Black stool when not taking iron supplements.....NO YES (10)

### SECTION D:

1. Seasonal diarrhea.....0 1 2 3
2. Frequent and recurrent infections (colds).....0 1 2 3
3. Bladder and kidney infections.....0 1 2 3
4. Vaginal yeast infection.....0 1 2 3
5. Abdominal cramps.....0 1 2 3
6. Toe and fingernail fungus.....0 1 2 3
7. Alternating diarrhea/constipation.....0 1 2 3
8. Constipation.....0 1 2 3
9. History of antibiotic.....NO YES
10. Meat eater.....NO YES
11. Rapidly failing vision.....NO YES

## PART 2

### SECTION A:

1. Difficulty breathing at night.....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 as extra beats.....0 1 2 3
8. Swelling of feet and ankles.....0 1 2 3
9. Rapid beating heart.....0 1 2 3
10. Heartburn after eating.....0 1 2 3
11. Pain in left arm.....0 1 2 3
12. Exhaustion with minor exertion.....0 1 2 3
13. Do you do aerobic exercise.....YES NO
14. Have you ever exercised regularly.....YES NO
15. Drink 5 or more cups of coffee daily.....NO YES
16. Severe cough.....NO YES
17. Has a doctor ever told you that you have heart trouble.....NO YES(6)

### 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.....0 1 2 3
9. Tingling and/or burning in hands or feet.....0 1 2 3
10. Spider veins on nose and/or face.....0 1 2 3

### SECTION C:

1. Pain when getting up in morning in back of head and neck.....0 1 2 3
2. Dizziness.....0 1 2 3
3. Vertigo.....0 1 2 3
4. Blushing with no apparent cause.....0 1 2 3
5. Is your blood pressure high?.....NO YES (10)

## PART 3

### 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 relieved by eating sweets or alcohol.....0 1 2 3
5. Feel shaky or jittery.....0 1 2 3
6. Irritable if a meal is missed.....0 1 2 3
7. Wake up in middle of night craving sweets.....0 1 2 3
8. Feel tired or weak if a meal is missed.....0 1 2 3
9. Hear 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 to 3 hours after eating.....0 1 2 3
13. Poor memory.....0 1 2 3
14. Feel faint.....0 1 2 3

15. Poor concentration.....0 1 2 3
16. Forgetful.....0 1 2 3
17. Calmer after eating.....0 1 2 3

### SECTION B:

1. Night sweats.....0 1 2 3
2. Increased thirst.....0 1 2 3
3. Lowered resistance to infection.....0 1 2 3
4. Fatigue.....0 1 2 3
5. Boils and leg sores.....0 1 2 3
6. Lesions, cuts take a long time to heal.....0 1 2 3
7. Overweight.....0 1 2 3
8. Feel pick up from exercise.....0 1 2 3
9. Failing eyesight.....0 1 2 3
10. Crave sweets, but eating sweets does not relieve symptoms.....0 1 2 3
11. Family history of diabetes.....0 1 2 3
12. Sugar in urine.....0 1 2 3

**PART 4****SECTION A:**

1. Intolerance to greasy foods.....	0	1	2	3
2. Headaches after eating.....	0	1	2	3
3. Light colored stool.....	0	1	2	3
4. Foul smelling stool.....	0	1	2	3
5. Less than one bowel movement daily.....	0	1	2	3
6. Constipation.....	0	1	2	3
7. Hard stool.....	0	1	2	3
8. Sour taste in mouth.....	0	1	2	3
9. Grey colored skin.....	0	1	2	3
10. Yellow in whites of eyes.....	0	1	2	3
11. Bad breath.....	0	1	2	3
12. Body odor.....	0	1	2	3
13. Fatigue and sleepiness after eating.....	0	1	2	3
14. Pain in right side under rib cage.....	0	1	2	3
15. Painful to pass stool.....	0	1	2	3
16. Retain water.....	0	1	2	3
17. Big toe painful.....	0	1	2	3
18. Pain radiates along outside of leg.....	0	1	2	3
19. Dry skin/hair.....	0	1	2	3
20. Red blood in stool.....	NO		YES <sup>(6)</sup>	
21. Have had jaundice or hepatitis.....	0	1	2	3
22. High blood cholesterol level and low HDL cholesterol.....	0	1	2	3
23. Is your cholesterol level above 200.....	NO	UNKNOWN	YES	
24. Is your triglyceride level above 115.....	NO	UNKNOWN	YES	

**SECTION B:**

1. Swollen eyes (bulging).....	0	1	2	3
2. Strong smelling urine.....	0	1	2	3
3. Thick skin and finger nails.....	0	1	2	3
4. Dry skin.....	0	1	2	3
5. Sensitive to the cold.....	0	1	2	3
6. Cold hands and feet.....	0	1	2	3
7. Excessive menstrual bleeding.....	0	1	2	3
8. Chronic fatigue.....	0	1	2	3
9. Trouble waking up in the morning.....	0	1	2	3
10. Depressed, apathetic.....	0	1	2	3
11. Low sex drive.....	0	1	2	3
12. Puffy, wrinkly skin.....	0	1	2	3
13. Sugar causes irritability and mood swings.....	0	1	2	3
14. Premenstrual tension.....	0	1	2	3
15. Constipation.....	0	1	2	3
16. Thinning or loss of outside portion of eyebrow.....	0	1	2	3
17. Gain weight easily.....	0	1	2	3
18. Anemia unaffected by iron.....	0	1	2	3
19. Axillary (armpit) temperature below 97.6°F.....	0	1	2	3
20. Slow reflexes.....	0	1	2	3
21. Infertility.....	0	1	2	3

**PART 5****SECTION A:**

1. Sensitive to exhaust fumes, smoke, smog, petrochemicals.....	0	1	2	3
2. Periodic constipation.....	0	1	2	3
3. Cannot tolerate exercise.....	0	1	2	3
4. Depression or rapid mood swings.....	0	1	2	3
5. Dark circles under the 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 easily when weather changes.....	0	1	2	3
9. Headaches.....	0	1	2	3
10. Difficulty breathing.....	0	1	2	3
11. Water retention.....	0	1	2	3
12. Eyes sensitive to bright light.....	0	1	2	3
13. Feel weak and shaky.....	0	1	2	3

**SECTION B:**

1. Inflamed and bleeding gums.....	0	1	2	3
2. Running 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 infection.....	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 back of arms.....	0	1	2	3

**SECTION C:**

1. Itching of nose or eyes.....	0	1	2	3 <sup>(5)</sup>
2. Itching of roof of mouth or throat.....	0	1	2	3 <sup>(5)</sup>
3. Migraine headaches.....	NO		YES <sup>(10)</sup>	
4. Entire body aches, painful to touch.....	0	1	2	3
5. Swollen joints.....	0	1	2	3
6. Food sensitivity or allergy.....	0	1	2	3
7. Certain foods make you sick, depressed, jittery.....	0	1	2	3
8. Chronic pain.....	0	1	2	3
9. Painful stomach and/or intestine.....	0	1	2	3
10. Alternating constipation and 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. Watery eyes.....	0	1	2	3
15. Puffiness or dark circles under eyes.....	0	1	2	3
16. Ear discharge or ears stuffed up.....	0	1	2	3
17. Nasal congestion.....	0	1	2	3
18. Running 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.....	NO		YES <sup>(5)</sup>	
23. Hyperactivity.....	0	1	2	3
24. Chronic lung congestion.....	0	1	2	3
25. Use of aspirin, tylenol regularly.....	NO		YES	
26. Wheezing.....	0	1	2	3
27. Skin rashes.....	0	1	2	3
28. Sneezing.....	0	1	2	3

**PART 6**

1. Chest pain.....	0	1	2	3
2. Chronic cough.....	0	1	2	3
3. Difficulty breathing.....	0	1	2	3
4. Coughing up blood.....	0	1	2	3
5. Coughing up phlegm.....	0	1	2	3
6. Pain around ribs.....	0	1	2	3
7. Shortness of breath.....	0	1	2	3

8. Rattling mucous when you breathe.....	0	1	2	3
9. Sensitive to smog.....	0	1	2	3
10. Infections settle in lungs.....	0	1	2	3
11. Live or work around people who smoke.....	0	1	2	3
12. Bronchitis.....	0	1	2	3
13. Exposed to chemicals and radiation.....	0	1	2	3
14. Smoker.....	0	1	2	3

**PART 7**

- |   |   |   |   |  |    |   |   |
|---|---|---|---|--|----|---|---|
| 1. Frequent urination.....0                 | 1 | 2 | 3 | 11. Strong smelling urine.....0  | 1  | 2 | 3 |
| 2. Frequent bladder infections.....0        | 1 | 2 | 3 | 12. Back or leg pains associated with<br>dripping after urination.....0  | 1  | 2 | 3 |
| 3. Rarely need to urinate.....0             | 1 | 2 | 3 | 13. History of kidney or bladder infections.....0                        | 1  | 2 | 3 |
| 4. Urination when you cough or sneeze.....0 | 1 | 2 | 3 | 14. Have used antibiotics to control<br>urinary tract infections.....YES | NO |   |   |
| 5. Painful/burning when passing urine.....0 | 1 | 2 | 3 | IF YES, WHEN DID YOU LAST USE THEM?<br>TREATMENT DURATION.....           |    |   |   |
| 6. Difficulty passing urine.....0           | 1 | 2 | 3 | 15. Back pain in the kidney area.....0                                   | 1  | 2 | 3 |
| 7. Dripping after urination.....0           | 1 | 2 | 3 | 16. General water retention.....0  | 1  | 2 | 3 |
| 8. Can't hold urine.....0                   | 1 | 2 | 3 |  |    |   |   |
| 9. Rose colored (bloody urine).....0        | 1 | 2 | 3 |  |    |   |   |
| 10. Cloudy urine.....0                      | 1 | 2 | 3 |  |    |   |   |

**PART 8 (Males Only)**

**SECTION A:**

- |  |   |   |   |
|--|---|---|---|
| 1. Difficulty urinating.....0  | 1 | 2 | 3 |
| 2. A sense of bladder fullness.....0   | 1 | 2 | 3 |
| 3. Increased straining with smaller and smaller<br>amounts of urine passed.....0 | 1 | 2 | 3 |
| 4. Rose colored (bloody) urine.....0   | 1 | 2 | 3 |
| 5. Pain or burning while urinating.....0   | 1 | 2 | 3 |
| 6. Wake up to urinate at night.....0   | 1 | 2 | 3 |
| 7. Dripping after urination.....0  | 1 | 2 | 3 |
| 8. Pain or fatigue in the legs or back.....0                                     | 1 | 2 | 3 |
| 9. Lack of sex drive.....0   | 1 | 2 | 3 |
| 10. Ejaculation causes pain.....0  | 1 | 2 | 3 |

**SECTION B:**

- |   |   |   |   |
|---|---|---|---|
| 1. Difficulty attaining and/or maintaining an erection....0 | 1 | 2 | 3 |
| 2. Low sexual drive.....0                                   | 1 | 2 | 3 |
| 3. Premature ejaculation.....0                              | 1 | 2 | 3 |
| 4. Pain/coldness in genital area.....0                      | 1 | 2 | 3 |
| 5. Infertile.....0  | 1 | 2 | 3 |
| 6. Varicose veins on scrotum.....0                          | 1 | 2 | 3 |
| 7. Low sperm count.....0                                    | 1 | 2 | 3 |

**SECTION C:**

- |   |                   |   |   |
|---|-------------------|---|---|
| 1. Discharge from penis.....0                                       | 1                 | 2 | 3 |
| 2. Past or present rash on penis.....0                              | 1                 | 2 | 3 |
| 3. Swollen genitals.....0   | 1                 | 2 | 3 |
| 4. Swelling in groin.....0  | 1                 | 2 | 3 |
| 5. Venereal disease (gonorrhea, syphilis<br>Herpes or other).....NO | YES               |   |   |
| Have V.D. now?.....   | Had in past?..... |   |   |

**PART 9 (Females Only)**

**SECTION A:** Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation. (Section A only)

- |                                    |   |   |   |
|------------------------------------|---|---|---|
| 1. Monthly weight gain.....0       | 1 | 2 | 3 |
| 2. Depression.....0                | 1 | 2 | 3 |
| 3. Moodiness/irritability.....0    | 1 | 2 | 3 |
| 4. Bloating and swelling.....0     | 1 | 2 | 3 |
| 5. Nausea and/or vomiting.....0    | 1 | 2 | 3 |
| 6. Suicidal feeling.....0          | 1 | 2 | 3 |
| 7. Anxiety.....0                   | 1 | 2 | 3 |
| 8. Leg cramps and tenderness.....0 | 1 | 2 | 3 |
| 9. Asthma attacks.....0            | 1 | 2 | 3 |
| 10. Headaches.....0                | 1 | 2 | 3 |
| 11. Easily distracted.....0        | 1 | 2 | 3 |
| 12. Anger.....0                    | 1 | 2 | 3 |
| 13. Tender breast.....0            | 1 | 2 | 3 |
| 14. Low backache.....0             | 1 | 2 | 3 |
| 15. Other.....0                    | 1 | 2 | 3 |
| 16. Age of onset of menses.....    |   |   |   |
| 17. Date of last menses.....       |   |   |   |

**SECTION B:**

- |   |                    |   |   |
|---|--------------------|---|---|
| 1. Vaginal itching.....0  | 1                  | 2 | 3 |
| 2. Vaginal discharge.....0  | 1                  | 2 | 3 |
| 3. Low or no desire for sex.....0                                 | 1                  | 2 | 3 |
| 4. Dislike for intercourse.....0                                  | 1                  | 2 | 3 |
| 5. Missed periods.....NO  | YES                |   |   |
| 6. Over 15 years of age and have not<br>begun menstruation.....NO | YES                |   |   |
| 7. Unable to get pregnant.....NO                                  | YES                |   |   |
| 8. Miscarriages.....NO  | YES HOW MANY?..... |   |   |
| 9. Abortion.....NO  | YES HOW MANY?..... |   |   |

**SECTION C:** Check if you experience any of these symptoms during menstruation (Section C only)

- |  |   |   |   |
|--|---|---|---|
| 1. Low abdominal pain.....0                      | 1 | 2 | 3 |
| 2. Dull ache radiating to low back or legs.....0 | 1 | 2 | 3 |
| 3. Increased urinary frequency.....0             | 1 | 2 | 3 |
| 4. Pelvic soreness.....0                         | 1 | 2 | 3 |
| 5. Diarrhea.....0                                | 1 | 2 | 3 |
| 6. Headaches.....0                               | 1 | 2 | 3 |
| 7. Abdominal bloating.....0                      | 1 | 2 | 3 |
| 8. Menstrual pain.....0                          | 1 | 2 | 3 |

- |  |   |   |   |
|--|---|---|---|
| 9. Nausea and/or vomiting.....0  | 1 | 2 | 3 |
| 10. Have to lie down on first 1 or 2 days of period.....0                | 1 | 2 | 3 |
| 11. Craving for sweets.....0   | 1 | 2 | 3 |
| 12. Insomnia.....0   | 1 | 2 | 3 |
| 13. Light scanty blood flow.....0  | 1 | 2 | 3 |
| 14. Pain and cramps without blood flow.....0                             | 1 | 2 | 3 |
| 15. Heavy menstrual bleeding.....0                                       | 1 | 2 | 3 |
| 16. Anxiety about menstrual cycle.....0                                  | 1 | 2 | 3 |
| 17. Pain during period is progressively getting<br>worse with time.....0 | 1 | 2 | 3 |

**SECTION D:**

- |  |          |   |   |
|--|----------|---|---|
| 1. Vaginal bumps and sores.....0   | 1        | 2 | 3 |
| 2. Pubic area sore.....0   | 1        | 2 | 3 |
| 3. Ovarian cysts.....NO  | YES (10) |   |   |
| 4. Uterine cysts.....NO  | YES (10) |   |   |
| 5. Pain in ovaries.....0   | 1        | 2 | 3 |
| 6. Breast lumps.....NO   | YES      |   |   |
| 7. Breasts sore to touch.....0   | 1        | 2 | 3 |
| 8. Breasts painful.....0   | 1        | 2 | 3 |
| 9. Water retention.....0   | 1        | 2 | 3 |
| 10. Swollen feeling.....0  | 1        | 2 | 3 |
| 11. Premenstrual breast pain or discomfort.....0   | 1        | 2 | 3 |
| 12. Mother used D.E.S. (hormones) while pregnant.....NO  | YES      |   |   |
| 13. Recent pap smear positive.....NO   | YES (15) |   |   |
| 14. Family history of breast cancer.....NO   | YES      |   |   |
| 15. Form of birth control: ___None ___Pill ___IUD ___Sponge<br>___Diaphragm ___Foam Other..... |          |   |   |

**SECTION E:**

- |  |   |   |   |
|--|---|---|---|
| 1. Hot flashes.....0                       | 1 | 2 | 3 |
| 2. Night sweats.....0                      | 1 | 2 | 3 |
| 3. Hysterectomy.....0                      | 1 | 2 | 3 |
| 4. Depression/mood swings.....0            | 1 | 2 | 3 |
| 5. Insomnia.....0                          | 1 | 2 | 3 |
| 6. Craving for sweets.....0                | 1 | 2 | 3 |
| 7. Heavy bleeding two weeks/month.....0    | 1 | 2 | 3 |
| 8. Sweating throughout day.....0           | 1 | 2 | 3 |
| 9. Dryness of skin, hair, and vagina.....0 | 1 | 2 | 3 |
| 10. Painful intercourse.....0              | 1 | 2 | 3 |
| 11. Vaginal pain.....0                     | 1 | 2 | 3 |
| 12. Vaginal itching.....0                  | 1 | 2 | 3 |
| 13. Osteoporosis (bone loss).....0         | 1 | 2 | 3 |

**PART 10**

1. Muscle spasms .....	0	1	2	3	6. Stiff all over.....	0	1	2	3
2. Tightness in shoulder muscles .....	0	1	2	3	7. Stiff in morning .....	0	1	2	3
3. Muscle cramps .....	0	1	2	3	8. Unable to sit straight .....	0	1	2	3
4. Pain in arms, hands .....	0	1	2	3	9. Pain in neck and/or shoulders .....	0	1	2	3
5. Leg cramps at nights .....	0	1	2	3	10. Back pain .....	0	1	2	3
					11. Joint pain .....	0	1	2	3

**PART 11**

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 .....	NO	YES	(10)	
4. Dizziness .....	0	1	2	3	13. Uncoordination.....	0	1	2	3
5. Ringing/buzzing in ears .....	0	1	2	3	14. Nervousness.....	0	1	2	3
6. Trembling hands .....	0	1	2	3	15. Accident prone .....	NO	YES		
7. Loss of feeling in hands and/or feet (toes) .....	0	1	2	3	16. Loss of muscle tone.....	NO	YES		
8. Exhaustion on slightest effort .....	0	1	2	3	17. Need for 10-12 hours sleep .....	NO	YES		
9. Limbs feel too heavy to hold up .....	0	1	2	3	18. Have had shingles.....	NO	YES		

**PART 12****SECTION A: Over the last year, I have experienced:**

1. Becoming forgetful.....	0	1	2	3
2. Lapses in memory.....	0	1	2	3
3. Becoming less attentive.....	0	1	2	3
4. Less interest in normal activities .....	0	1	2	3
5. Feeling less sharp .....	0	1	2	3
6. Difficulty remembering people's names.....	0	1	2	3
7. Difficulty making decisions .....	0	1	2	3
8. Problems finding the right words to communicate .....	0	1	2	3
9. Difficulty solving routine problems .....	0	1	2	3
10. Difficulty learning new things.....	0	1	2	3
11. Problems writing, reading, or organizing thoughts.....	0	1	2	3
12. Difficulty following instructions.....	0	1	2	3

**SECTION B: I experience:**

1. Lack of interest in normal activities.....	0	1	2	3
2. Loss of energy .....	0	1	2	3
3. Oversleeping or sleepiness .....	0	1	2	3
4. Sense of sadness for no apparent reason .....	0	1	2	3
5. Increased appetite, especially for carbohydrates.....	0	1	2	3
6. Fatigue .....	0	1	2	3
7. Symptoms that usually get worse in the winter .....	0	1	2	3
8. Weight gain or weight loss .....	0	1	2	3
9. Difficulty concentrating and processing Information, especially in the afternoon .....	0	1	2	3
10. Diminished sexual desire.....	0	1	2	3

**SECTION C: I frequently**

1. Feel tense and have trouble relaxing.....	0	1	2	3
2. Have headaches and other aches and pains.....	0	1	2	3
3. Get crabby or grouchy.....	0	1	2	3
4. Have trouble falling asleep or staying asleep.....	0	1	2	3
5. Sweat and have hot flashes in anticipation of events .....	0	1	2	3
6. Feel irritable or short tempered .....	0	1	2	3
7. Have trouble letting go of things.....	0	1	2	3
8. Get angry for no apparent reason .....	0	1	2	3
9. Women only: Get worse symptoms prior to getting my period.....	0	1	2	3

**SECTION D: I often:**

1. Feel overly active and compelled to do things, like being driven by a motor.....	0	1	2	3
2. Have difficulty relaxing and unwinding when I have time to myself .....	0	1	2	3
3. Misplace and have difficulty finding things .....	0	1	2	3
4. Crave caffeine and stimulants to keep me going.....	0	1	2	3
5. Delay getting started when I have a task or work that requires a lot of thought.....	0	1	2	3
6. Get easily distracted by activity or noise around me...0	1	2	3	
7. Have difficulty keeping my attention when doing boring and repetitive work.....	0	1	2	3
8. Fidget or squirm with my hands and feet when I have to sit down for a long time .....	0	1	2	3
9. Leave my seat in meetings or other situations in which I am expected to remain seated.....	0	1	2	3
10. Have problems remembering appointments or obligations .....	0	1	2	3
11. Have difficulty concentrating on what people say to me, even when they are speaking directly to me.....	0	1	2	3
12. Move around and kick in my sleep .....	0	1	2	3

**SECTION E: I experience:**

1. Waking up frequently during the night with difficulty returning to sleep.....	0	1	2	3
2. Looking forward to catching up on my sleep on the weekends.....	0	1	2	3
3. Taking more than 30 minutes to fall asleep at night ...0	1	2	3	
4. Stomach problems or nausea .....	0	1	2	3
5. Waking up repeatedly throughout the night .....	0	1	2	3
6. Waking up groggy and not well rested.....	0	1	2	3
7. Preferring to go to sleep later than midnight and waking up late, after 10:00 a.m. ....	0	1	2	3
8. Preferring an early bedtime – going to sleep between 7 p.m. and 9 p.m. and waking up early, around 5:00 a.m.....	0	1	2	3
9. Jet lag .....	0	1	2	3
10. Difficulty turning off my thoughts when I lay down to sleep.....	0	1	2	3