Health Appraisal Questionnaire Female Version

| Do you have: |  |
| :---: | :---: |
| Frequent stuffy or watery nose, sneezing | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| An allergy to any medications | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Asthma or notice yourself wheezing | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Chronic bronchitis or emphysema | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| A frequent cough for any reason | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Shortness of breath | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Have you ever: |  |
| Coughed up blood (coughed not vomited) | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Been treated for TB or Coccidomycosis (Valley Fever) | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Had a positive TB test | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Been a smoker | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| If now a smoker how many cigarettes a day $\qquad$ |  |


| Had lung cancer | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| :---: | :---: |
| Do you chew tobacco | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Have you ever had, or ever been told you have: |  |
| High blood pressure | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| To take blood pressure medicine | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| A heart attack (coronary) | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| To take medicine to lower your cholesterol | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Do you get: |  |
| Pains or heavy pressure in your chest with exertion | $\begin{aligned} & \hline 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Do you use nitroglycerin | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Episodes of fast heart beats or skipped beats | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Other heart problems | $\begin{aligned} & \hline 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Nocturnal leg cramps | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Leg pains from rapid or uphill walking, stairs | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Do you have: |  |


| Varicose veins | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| :---: | :---: |
| Any skin problems | $\begin{aligned} & 1=\mathrm{yes} \\ & 2=\text { no } \end{aligned}$ |
| Are you troubled by: |  |
| Abdominal (stomach) pains | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Frequent indigestion or heartburn | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Constipation | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Frequent diarrhea, loose bowels | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Has there been a definite change: |  |
| In the pattern or regularity of your bowel movements in the last year | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Are you a vegetarian | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Have you ever had, or been told you have: |  |
| An ulcer | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Vomited blood | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Black tar-like bowel movements | $\begin{aligned} & 1=\mathrm{yes} \\ & 2=\text { no } \end{aligned}$ |
| Gallstones, gallbladder problems | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |


| Yellow jaundice, hepatitis, or any liver trouble | $\begin{aligned} & 1=\mathrm{yes} \\ & 2=\text { no } \end{aligned}$ |
| :---: | :---: |
| Definite change in your weight in recent months | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Are you troubled by: |  |
| Frequent headaches | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Attacks of dizziness | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Have you ever |  |
| Had seizures, convulsions, fits | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Fainted or lost consciousness for no obvious reason | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Temporarily lost control of a hand or foot (paralysis) | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Had a stroke or "small stroke" | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Been temporarily unable to speak | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Are you troubled by: |  |
| Frequent back pain | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Pain or swelling in your joints | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Have you ever: |  |


| Broken any bones | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| :---: | :---: |
| Frequently worried about being ill | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Been troubled as a result of being more sensitive than most people | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Had special circumstances in which you find yourself panicked | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Had reason to fear your anger getting out of control | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Have you had, or do you have: |  |
| Any problems with your urinary tract (kidney, bladder) | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Loss of control of your urine | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Pain or burning when you urinate | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Blood in your urine | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Trouble starting the flow of urine | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| To get up repeatedly at night to urinate | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Vaginal bleeding between periods | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |


| After menopause, any vaginal bleeding whatsoever | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| :---: | :---: |
| A noticable lump in your breast | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Do breast self-exams regularly | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Discharge from your nipples | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Have you ever been treated for or told you had: |  |
| Any venereal disease | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Diabetes | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| To take medicine for diabetes | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Thyroid disease | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Cancer | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Have you ever had or do you now have: |  |
| Radiation therapy | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Trouble refusing requests or saying "No" | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Hallucinations (seen, smelled, or heard things that were not really there | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |



| In the past year, about how many visits to a doctor have you made |  |
| :---: | :---: |
| How far have you gone in school |  |
| Are you married | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| How many times have you been married | . |
| Are you now having serious or disturbing problems with your: |  |
| Marriage | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Family | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Drug usage | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Job | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Financial matters | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Have you ever had coronary artery surgery | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |
| Approximate year | . |
| Did you have a blood transfusion between 1978 and 1985 | $\begin{aligned} & 1=\text { yes } \\ & 2=\text { no } \end{aligned}$ |


| Do you feel you need any immunizations | 1,2,. |
| :---: | :---: |
| Are you retired | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Have members of your family died before the age of 65 ? | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Are there diseases which a number of family members have had? | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Are there any unusual illnesses in your family you didn't list previously? | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Has a parent, brother, or sister developed coronary (heart) disease before age 60? | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Do you have an identical twin? | $\begin{aligned} & 1=y e s \\ & 2=\text { no } \end{aligned}$ |
| Please fill in the circle that you think best describes your current state of health | $\begin{aligned} & \text { 1=excellent } \\ & 2=\text { good } \\ & 3=\text { fair } \\ & \text { 4=poor } \end{aligned}$ |
| Do you regularly use seat belts in a car? | $\begin{aligned} & \text { 1=yes } \\ & 2=\text { no } \end{aligned}$ |
| Please fill in the circle that best describes your stress level: | $\begin{aligned} & \text { 1=high } \\ & 2=\text { medium } \\ & \text { 3=low } \end{aligned}$ |
| Year of last mammogram |  |


| EXAMNATION DATA |  |
| :--- | :--- |

