Health Appraisal Questionnaire Female Version

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

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

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

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| Yellow jaundice, hepatitis, or any liver trouble | 1=yes 2=no |
| Definite change in your weight in recent months | 1=yes 2=no |
| ***Are you troubled by:*** |  |
| Frequent headaches | 1=yes 2=no |
| Attacks of dizziness | 1=yes 2=no |
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| ***Have you ever*** |  |
| Had seizures, convulsions, fits | 1=yes 2=no |
| Fainted or lost consciousness for no obvious reason | 1=yes 2=no |
| Temporarily lost control of a hand or foot (paralysis) | 1=yes 2=no |
| Had a stroke or “small stroke” | 1=yes 2=no |
| Been temporarily unable to speak | 1=yes 2=no |
| ***Are you troubled by:*** |  |
| Frequent back pain | 1=yes 2=no |
| Pain or swelling in your joints | 1=yes 2=no |
| ***Have you ever:*** |  |

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

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

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| Trouble falling asleep or staying asleep | 1=yes 2=no |
| Tiredness, even after a good night’s sleep | 1=yes 2=no |
| Crying spells | 1=yes 2=no |
| Depression or “feel down in the dumps” | 1=yes 2=no |
| Much trouble with nervousness | 1=yes 2=no |
| ***Do you:*** |  |
| Sometimes drink more than is good for you | 1=yes 2=no |
| Use street drugs | 1=yes 2=no |
| ***Have you ever:*** |  |
| Been raped, or sexually molested as a child | 1=yes 2=no |
| ***Are you:*** |  |
| Currently sexually active with a partner | 1=yes 2=no |
| Satisfied with your sex life | 1=yes 2=no |
| Concerned you are at risk for AIDS | 1=yes 2=no |
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| ***Please tell us:*** |  |

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| In the past year, about how many visits to a doctor have youmade | . |  |
| How far have you gone in school | . |
| Are you married | 1=yes 2=no |
|  | How many times have you been married | . |
|  | ***Are you now having serious or disturbing problems with your:*** |  |
|  | Marriage | 1=yes 2=no |
|  | Family | 1=yes 2=no |
|  | Drug usage | 1=yes 2=no |
|  | Job | 1=yes 2=no |
|  | Financial matters | 1=yes 2=no |
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|  | Have you ever had coronary artery surgery | 1=yes 2=no |
|  | Approximate year | . |
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|  | Did you have a blood transfusion between 1978and 1985 | 1=yes 2=no |
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| Do you feel you need any immunizations | 1,2,. |
| Are you retired | 1=yes 2=no |
| Have members of your family died before the age of 65? | 1=yes 2=no |
| Are there diseases which a number of family members have had? | 1=yes 2=no |
| Are there any unusual illnesses in your family you didn’t list previously? | 1=yes 2=no |
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| Has a parent, brother, or sister developed coronary (heart) disease before age 60? | 1=yes 2=no |
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| Do you have an identical twin? | 1=yes 2=no |
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| Please fill in the circle that you think best describes your current state of health | 1=excellent 2=good 3=fair 4=poor |
| Do you regularly use seat belts in a car? | 1=yes 2=no |
| Please fill in the circle that best describes your stress level: | 1=high 2=medium 3=low |
| Year of last mammogram |  |

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| ***EXAMINATION DATA*** |  |