

# HEALTH ANALYSIS

No. \_\_\_\_\_

Date \_\_\_\_\_

Patient \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced

Age \_\_\_\_\_ Occupation \_\_\_\_\_

## *Please Circle the Appropriate Answer.*

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 often 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 nosebleeds? -----	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