HEALTH ANALYSIS

Date _____

Patient_____

Age _____ Recreational Activities_____

Please Circle the Appropriate Answer.

1. Do you suffer from regular spells of sneezing?..... Yes No
2. Do you suffer from running/stuffed up nose or hay fever?..... Yes No
3. Do you often catch colds?..... Yes No
4. Do you have frequent coughing?..... Yes No
5. Do you have difficulty breathing?..... Yes No
6. Do you suffer from asthma?..... Yes No
7. Do you have night sweats?..... Yes No
   Please Explain:_____
8. Has a doctor ever said your blood pressure was too high?..... Yes No
9. Has a doctor ever said your blood pressure was too low?..... Yes No
10. Has a doctor ever said you had heart trouble?..... Yes No
11. Does heart trouble run in your family?..... Yes No
12. Have you had <u>unexplained</u> weight loss?..... Yes No
13. Do you need to lose more than 10 pounds..... Yes No
14. Do your muscles and joints feel stiff or swollen?..... Yes No
15. Does arthritis run in your family?..... Yes No
16. Do you suffer from severe headaches?..... Yes No
17. Do you often have spells of severe dizziness?..... Yes No
18. Do you usually feel unhappy and depressed?..... Yes No
19. Do you have numbness or tingling in any part of your body?..... Yes No
20. Were you knocked unconscious in the last year?..... Yes No
    Please Explain:_____
21. Do you have diabetes?..... Yes No
22. Did a doctor ever treat you for a tumor or cancer?..... Yes No
    Year/diagnosis:_____
23. Does cancer run in your family?..... Yes No
    Please Explain:_____
24. Do you suffer from any chronic disease?..... Yes No
25. Have you had a serious operation?..... Yes No
    Year/diagnosis:_____
27. Do you usually take two or more alcoholic drinks a day?..... Yes No

28. Grade Intensity/Severity:(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse possible pain imaginable)

29. Language_____
30. Ethnicity _____Hispanic_____not Hispanic
31. Race_____

33. ***<u>WOMEN:</u>*** **ARE YOU PREGNANT? YES NO**

Signature:_____