(MEN)

HEALTH QUESTIONNAIRE

Date _____

Print Your Name _____ Your Home Address _____

How Old Are You? _____ Circle If You Are . . . Single, Married, Widowed, Separated, Divorced.

Circle the Highest Year You Reached In School 1 2 3 4 5 6 7 8 (Elementary School) 1 2 3 4 (High) 1 2 3 4 (College)

What is Your Occupation? _____

Directions: This questionnaire is for MEN ONLY. Women included on later pages
If you can answer YES to the question asked, put a circle around the YES
If you have to answer NO to the question asked, put a circle around the NO
Answer all questions. If you are not sure, guess.

A

Do you need glasses to read?	Yes	No	001
Do you need glasses to see things at a distance?	Yes	No	002
Do your eyes continually blink or water?	Yes	No	003
Are your eyes often red or inflamed?	Yes	No	004
Has your eyesight often blacked out completely?	Yes	No	005
Do you often have severe pains in your eyes?	Yes	No	006
Have you had cataracts?	Yes	No	007
Have you ever been told you have glaucoma?	Yes	No	008
Do you wear contact lenses?	Yes	No	009
Have you ever had double vision?	Yes	No	010
Are you hard of hearing?	Yes	No	011
Have you worn a hearing aid?	Yes	No	012
Do you notice a ringing in your ear(s)?	Yes	No	013

B

Do you have to clear your throat frequently?	Yes	No	014
Do you often feel a choking lump in your throat?	Yes	No	015
Is your nose continually stuffed up?	Yes	No	016
Does your nose run constantly?	Yes	No	017
Have you ever had a bad nose bleed?	Yes	No	018
Do you frequently suffer from severe colds?	Yes	No	019
Do frequent colds keep you miserable all winter?	Yes	No	020
Do you get hay fever?	Yes	No	021
Do you suffer from asthma?	Yes	No	022
Do you have a sinus condition?	Yes	No	(
Are you troubled by constant coughing?	Yes	No	(
Have you ever coughed up any blood?	Yes	No	(
Do you suffer from bronchitis?	Yes	No	(
Do you sometimes have severe soaking sweats at night?	Yes	No	(
Have you had a chest X-ray in the last 2 years?	Yes	No	(
Have you ever had pneumonia?	Yes	No	(
Are you a smoker?	Yes	No	(

C

Do you suffer from angina?	Yes	No
Have you ever had a heart attack?	Yes	No
Does heart trouble run in your family	Yes	No
Have you ever had an electro-cardiogram?	Yes	No
Have you ever had a stress (exercise tolerance) test?	Yes	No
Do you wake up at night short of breath?	Yes	No
Do you get regular (daily) exercise?	Yes	No
Has a doctor ever said your blood pressure was too high or low?	Yes	No
Have you ever been told of high blood cholesterol?	Yes	No
Do you have pains in the heart or chest?	Yes	No
Does your heart often race like mad?	Yes	No
Do you find it hard to breath?	Yes	No
Do you get out of breath long before anyone else?	Yes	No
Have you ever been told to take antibiotics during dental work?	Yes	No