

Health Appraisal Questionnaire

Basic Form

PATIENT
NUMBER _____

Name _____

Date ____/____/____

Part I

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Anti Diabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone/Anti-inflammatories
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Recreational Drugs
- Specify _____
- Relaxants/Sleeping Pills
- Thyroid
- Ulcer Medications
- Other _____

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated beverages
- Cigarettes
- Coffee
- Distilled water
- Fast food, regularly
- Fried Foods
- Luncheon meats
- Margarine
- Vitamins and/or minerals (Please list)
- Refined sugars
- Saccharine (Sweet & Low)
- Chew Tobacco

Circle if you:

- Diet often
- Do not exercise regularly
- Salt food without tasting
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.
 0= Symptom is not present 1 = Mild 2= Moderate 3= Severe

Part II

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Burping | 0 | 1 | 2 | 3 |
| 2. Fullness for extended time after meals | 0 | 1 | 2 | 3 |
| 3. Bloating | 0 | 1 | 2 | 3 |
| 4. Poor appetite | 0 | 1 | 2 | 3 |
| 5. Stomach upsets easily | 0 | 1 | 2 | 3 |
| 6. History of constipation | 0 | 1 | 2 | 3 |
| 7. Known food allergies | 0 | 1 | 2 | 3 |

SECTION B:

- | | | | | |
|---|---|---|---|---|
| 1. Abdominal cramps | 0 | 1 | 2 | 3 |
| 2. Indigestion 1-3 hours after eating | 0 | 1 | 2 | 3 |
| 3. Fatigue after eating | 0 | 1 | 2 | 3 |
| 4. Lower bowel gas | 0 | 1 | 2 | 3 |
| 5. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 6. Diarrhea | 0 | 1 | 2 | 3 |
| 7. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 8. Mucous in stools | 0 | 1 | 2 | 3 |
| 9. Stool poorly formed | 0 | 1 | 2 | 3 |
| 10. Shiny stool | 0 | 1 | 2 | 3 |
| 11. Three or more large bowel movements daily | 0 | 1 | 2 | 3 |
| 12. Foul smelling stool | 0 | 1 | 2 | 3 |
| 13. Dry, flaky skin and/or dry brittle hair | 0 | 1 | 2 | 3 |
| 14. Pain in left side under rib cage | 0 | 1 | 2 | 3 |
| 15. Acne | 0 | 1 | 2 | 3 |
| 16. Food allergies | 0 | 1 | 2 | 3 |
| 17. Difficulty gaining weight | 0 | 1 | 2 | 3 |

SECTION C:

- | | | | | |
|---|----|---|---|----------|
| 1. Stomach pains | 0 | 1 | 2 | 3 |
| 2. Stomach pains just before and/or after meals | 0 | 1 | 2 | 3 |
| 3. Dependency on antacids | 0 | 1 | 2 | 3 |
| 4. Chronic abdominal pain | 0 | 1 | 2 | 3 |
| 5. Butterfly sensations in stomach | 0 | 1 | 2 | 3 |
| 6. Difficulty belching | 0 | 1 | 2 | 3 |
| 7. Stomach pain when emotionally upset | 0 | 1 | 2 | 3 |
| 8. Sudden, acute indigestion | No | | | Yes |
| 9. Relief of symptoms by carbonated beverages | No | | | Yes |
| 10. Relief of stomach pain by drinking cream/milk | No | | | Yes |
| 11. History of ulcer or gastritis | No | | | Yes |
| 12. Current ulcer | No | | | Yes (10) |
| 13. Black stool when not taking iron supplements | No | | | Yes (10) |

SECTION D:

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|--|----|---|---|-----|
| 1. Seasonal diarrhea | 0 | 1 | 2 | 3 |
| 2. Frequent and recurrent infections (colds) | 0 | 1 | 2 | 3 |
| 3. Bladder and kidney infections | 0 | 1 | 2 | 3 |
| 4. Vaginal yeast infection | 0 | 1 | 2 | 3 |
| 5. Abdominal cramps | 0 | 1 | 2 | 3 |
| 6. Toe and Fingernail Fungus | 0 | 1 | 2 | 3 |
| 7. Alternating diarrhea/constipation | 0 | 1 | 2 | 3 |
| 8. Constipation | 0 | 1 | 2 | 3 |
| 9. History of antibiotic use | No | | | Yes |
| 10. Meat eater | No | | | Yes |
| 11. Rapidly Failing vision | No | | | Yes |

Part III

SECTION A:

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|---|---|---|---|---|
| 1. Intolerance to greasy foods | 0 | 1 | 2 | 3 |
| 2. Headaches after eating | 0 | 1 | 2 | 3 |
| 3. Light colored stool | 0 | 1 | 2 | 3 |
| 4. Foul smelling stool | 0 | 1 | 2 | 3 |
| 5. Less than one bowel movement daily | 0 | 1 | 2 | 3 |
| 6. Constipation | 0 | 1 | 2 | 3 |
| 7. Hard stool | 0 | 1 | 2 | 3 |
| 8. Sour taste in mouth | 0 | 1 | 2 | 3 |

- | | | | | |
|---|----|---|---|----------|
| 9. Gray colored skin | 0 | 1 | 2 | 3 |
| 10. Yellow in whites of eyes | 0 | 1 | 2 | 3 |
| 11. Bad breath | 0 | 1 | 2 | 3 |
| 12. Body odor | 0 | 1 | 2 | 3 |
| 13. Fatigue and sleepiness after eating | 0 | 1 | 2 | 3 |
| 14. Pain in right side under rib cage | 0 | 1 | 2 | 3 |
| 15. Painful to pass stool | 0 | 1 | 2 | 3 |
| 16. Retain water | 0 | 1 | 2 | 3 |
| 17. Big toe painful | 0 | 1 | 2 | 3 |
| 18. Pain radiates along outside of leg | 0 | 1 | 2 | 3 |
| 19. Dry skin/hair | 0 | 1 | 2 | 3 |
| 20. Red blood in stool | No | | | Yes (10) |

