

(WOMEN)

WOMEN

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 *WOMEN ONLY*

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 023
- Are you troubled by constant coughing? Yes No 024
- Have you ever coughed up any blood? Yes No 025
- Do you suffer from bronchitis? Yes No 026
- Do you sometimes have severe soaking sweats at night? Yes No 027
- Have you had a chest X-ray in the last 2 years? Yes No 028
- Have you ever had pneumonia? Yes No 029
- Are you a smoker? Yes No 030

- C**
- Do you suffer from angina? Yes No 031
 - Have you ever had a heart attack? Yes No 032
 - Does heart trouble run in your family Yes No 033
 - Have you ever had an electro-cardiogram? Yes No 034
 - Have you ever had a stress (exercise tolerance) test? Yes No 035
 - Do you wake up at night short of breath? Yes No 036
 - Do you get regular (daily) exercise? Yes No 037
 - Has a doctor ever said your blood pressure was too high or low? Yes No 038
 - Have you ever been told of high blood cholesterol? Yes No 039
 - Do you have pains in the heart or chest? Yes No 040
 - Does your heart often race like mad? Yes No 041
 - Do you find it hard to breath? Yes No 042
 - Do you get out of breath long before anyone else? Yes No 043
 - Have you ever been told to take antibiotics during dental work? Yes No 044