Health Appraisal Questionnaire
Male Version

Verbatim Question	**Coding and comments**
***Do you have*:**	
Frequent stuffy or watery nose, sneezing	1=yes 2=no
An allergy to any medications	1=yes 2=no
Asthma or notice yourself wheezing	1=yes 2=no
Chronic bronchitis or emphysema	1=yes 2=no
A frequent cough for any reason	1=yes 2=no
Shortness of breath	1=yes 2=no
Have you ever:	
Coughed up blood (coughed not vomited)	1=yes 2=no
Been treated for TB or Coccidomycosis (Valley Fever)	1=yes 2=no
Had a positive TB test	1=yes 2=no
Been a smoker	1=yes 2=no

If now a smoker how many cigarettes a day _____	
Had lung cancer	1=yes 2=no
Do you chew tobacco	1=yes 2=no
Have you ever had, or ever been told you have:	
High blood pressure	1=yes 2=no
To take blood pressure medicine	1=yes 2=no
A heart attack (coronary)	1=yes 2=no
To take medicine to lower your cholesterol	1=yes 2=no
Do you get:	
Pains or heavy pressure in your chest with exertion	1=yes 2=no
Do you use nitroglycerin	1=yes 2=no
Episodes of fast heart beats or skipped beats	1=yes 2=no
Other heart problems	1=yes 2=no
Nocturnal leg cramps	1=yes 2=no

Leg pains from rapid or uphill walking, stairs	1=yes 2=no
Do you have:	
Varicose veins	1=yes 2=no
Any skin problems	1=yes 2=no
Are you troubled by:	
Abdominal (stomach) pains	1=yes 2=no
Frequent indigestion or heartburn	1=yes 2=no
Constipation	1=yes 2=no
Frequent diarrhea, loose bowels	1=yes 2=no
Has there been a definite change:	
In the pattern or regularity of your bowel movements in the last year	1=yes 2=no
Are you a vegetarian	1=yes 2=no
Have you ever had, or been told you have:	
An ulcer	1=yes 2=no
Vomited blood	1=yes 2=no

Black tar-like bowel movements	1=yes 2=no
Gallstones, gallbladder problems	1=yes 2=no
Yellow jaundice, hepatitis, or any liver trouble	1=yes 2=no
Definite change in your weight in recent months	1=yes 2=no
Are you troubled by:	
Frequent headaches	1=yes 2=no
Attacks of dizziness	1=yes 2=no
Have you ever	
Had seizures, convulsions, fits	1=yes 2=no
Fainted or lost consciousness for no obvious reason	1=yes 2=no
Temporarily lost control of a hand or foot (paralysis)	1=yes 2=no
Had a stroke or “small stroke”	1=yes 2=no
Been temporarily unable to speak	1=yes 2=no
Are you troubled by:	

Frequent back pain	1=yes 2=no
Pain or swelling in your joints	1=yes 2=no
Have you ever:	
Broken any bones	1=yes 2=no
Frequently worried about being ill	1=yes 2=no
Been troubled as a result of being more sensitive than most people	1=yes 2=no
Had special circumstances in which you find yourself panicked	1=yes 2=no
Had reason to fear your anger getting out of control	1=yes 2=no
Have you had, or do you have:	
Any problems with your urinary tract (kidney, bladder)	1=yes 2=no
Loss of control of your urine	1=yes 2=no
Pain or burning when you urinate	1=yes 2=no
Blood in your urine	1=yes 2=no
Trouble starting the flow of urine	1=yes 2=no

To get up repeatedly at night to urinate	1=yes 2=no
Discharge from your nipples	1=yes 2=no
Have you ever been treated for or told you had:	
Any venereal disease	1=yes 2=no
Diabetes	1=yes 2=no
To take *medicine* for diabetes	1=yes 2=no
Thyroid disease	1=yes 2=no
Cancer	1=yes 2=no
Have you ever had or do you now have:	
Radiation therapy	1=yes 2=no
Trouble refusing requests or saying “No”	1=yes 2=no
Hallucinations (seen, smelled, or heard things that were not really there	1=yes 2=no
Trouble falling asleep or staying asleep	1=yes 2=no
Tiredness, even after a good night’s sleep	1=yes 2=no

Crying spells	1=yes 2=no
Depression or “feel down in the dumps”	1=yes 2=no
Much trouble with nervousness	1=yes 2=no
Do you:	
Sometimes drink more than is good for you	1=yes 2=no
Use street drugs	1=yes 2=no
Have you ever:	
Been raped, or sexually molested as a child	1=yes 2=no
Are you:	
Currently sexually active with a partner	1=yes 2=no
Satisfied with your sex life	1=yes 2=no
Concerned you are at risk for AIDS	1=yes 2=no
Please tell us:	
In the past year, about how many visits to a doctor have you made_____	.
How far have you gone in school	.

Are you married	1=yes 2=no
How many times have you been married_____	.
Are you now having serious or disturbing problems with your:	
Marriage	1=yes 2=no
Family	1=yes 2=no
Drug usage	1=yes 2=no
Job	1=yes 2=no
Financial matters	1=yes 2=no
Have you ever had coronary artery surgery	1=yes 2=no
Approximate year	Range: 1-96 .
Did you have a blood transfusion between 1978 and 1985	1,2,.
Do you feel you need any immunizations	1,2,.
Are you retired	1=yes 2=no

Have members of your family died before the age of 65?	1=yes 2=no
Are there diseases which a number of family members have had?	1=yes 2=no
Are there any unusual illnesses in your family you didn't list previously?	1=yes 2=no
Has a parent, brother, or sister developed coronary (heart) disease before age 60?	1=yes 2=no
Do you have an identical twin?	1=yes 2=no
Please fill in the circle that you think best describes your current state of health	1=excellent 2=good 3=fair 4=poor
Do you regularly use seat belts in a car?	1=yes 2=no
Please fill in the circle that best describes your stress level:	1=high 2=medium 3=low