Name_____ Date_____

Health Appraisal Questionnaire

Directions:

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help to keep track of how your physical, mental, and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes you symptoms:

0 = no or rarely – you have never experienced the symptom or symptom is familiar but you perceive it as insignificant (monthly or less)
1 = occasionally – symptom comes and goes and is linked in your mind to stress, diet, fatigue, or some identifiable trigger
4 = often – symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it
8 = frequently – symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis.

Some questions require a Yes or No response. 0 = no 8 = yes

PART I - SECTION A

1.Indigestion, food repeats on you after you eat	0	1	4	8
2.Excessive burping, belching and/or bloating following meals	0	1	4	8
3.Stomach spasms & cramping during or after eating	0	1	4	8
4.A sensation that food just sits in your stomach creating uncomfortable fullness, pressure & bloating during or after a meal	0	1	4	8
5.Bad taste in your mouth	0	1	4	8
6.Small amounts of food fill you up immediately	0	1	4	8
7.Skip meals or eat erratically because you have no appetite	0	1	4	8

TOTAL POINTS:

PART I - SECTION B

1.Strong emotions, of the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2.Feel hungry an hour or two after eating a good sized meal	0	1	4	8
3.Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4.Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids	0	1	4	8
5.Buring sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6.Digestive problems subside with rest & relaxation	0(no)			8(yes)
7.Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8.Feel a sense of nausea when you eat	0	1	4	8
9.Difficulty or pain when swallowing food or beverage	0	1	4	8

TOTAL POINTS:

PART I - SECTION C

1.When massaging under your rib cage on your **left** side, there is pain, tenderness or soreness	0	1	4	8
2.Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3.Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4.Specific foods/beverages aggravate indigestion	0	1	4	8
5.The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8
6.Stool odor is embarrassing	0	1	4	8
7.Undigested food in your stool	0	1	4	8
8.Three or more large bowel movements daily	0	1	4	8
9.Diarrhea (frequent loose, watery stool)	0	1	4	8
10.Bowel movement shortly after eating (within one hour)	0	1	4	8

TOTAL POINTS:

PART I - SECTION D

1.Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2.Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3.Generally constipated (or straining during bowel movements)	0	1	4	8

PART I - SECTION D continued

4.Stool is small, hard and dry	0	1	4	8
5.Pass mucous in your stool	0	1	4	8
6.Alternate between constipation and diarrhea	0	1	4	8
7.Rectal pain, itching or cramping	0	1	4	8
8.No urge to have a bowel movement	0(no)			8(yes)
9.An almost continual need to have a bowel movement	0(no)			8(yes)

TOTAL POINTS:

PART II

1.When massaging under your rib cage on your **right** side, there is pain, tenderness or soreness	0	1	4	8
2.Abdominal pain worsens with deep breathing	0	1	4	8
3.Pain at night that may move to your back or right shoulder	0	1	4	8
4.Bitter fluid repeats after eating	0	1	4	8
5.Feel abdominal discomfort or nausea when eating rich, fatty or fired foods	0	1	4	8
6.Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7.Unexplained itchy skin worse at night	0	1	4	8
8.Stool color alternates from clay colored to normal brown	0	1	4	8
9.General feeling of poor health	0	1	4	8
10.Aching muscles not due to exercise	0	1	4	
11.Retain fluid and feet swollen around the ankles	0	1	4	8
12.Reddened skin, especially palms	0	1	4	8
13.Very strong body odor	0	1	4	8
14.Are you embarrassed by your breath?	0	1	4	8
15.Bruise easily	0(no)			8(yes)
16.Yellowish cast to eyes	0(no)			8(yes)

TOTAL POINTS:

PART III - SECTION A

1.Feel cold or chilled – hands, feet, all over- for no apparent reason	0	1	4	8
2.Your upper eyelids look swollen	0	1	4	8
3.Muscles are weak, cramp and/or tremble	0	1	4	8
4.Are you forgetful?	0	1	4	8
5.Do you feel like your heart beats slowly?	0	1	4	8
6.Reaction time seems slowed down	0	1	4	8
7.In general, are you disinterested in sex because your desire is low?	0	1	4	8
8.Feel slow-moving, sluggish	0	1	4	8
9.Constipation	0	1	4	8
10.Dryness, discoloration of skin and or/hair	0(no)			8(yes)
11.Have you noticed recently that your voice is deepening?	0(no)			8(yes)
12.Thick, brittle nails	0(no)			8(yes)
13.Weight gain for no apparent reason	0(no)			8(yes)
14.Outer third of your eyebrow is thinning or disappearing	0(no)			8(yes)
15.Swelling of neck	0(no)			8(yes)

TOTAL POINTS:

PART III - SECTION B

1.Lingering mild fatigue after exertion or stress	0	1	4	8
2.Do you find that you get tired and exhaust easily?	0	1	4	8
3.Craving for salty foods?	0	1	4	8
4.Senstive to minor changes in weather and surroundings	0	1	4	8
5.Dizzy when rising or standing up from a kneeling position	0	1	4	8
6.Dark bluish or black circles under your eyes	0	1	4	8
7.Have bouts of nausea with or without vomiting	0	1	4	8
8.Catch colds or infections easily	0(no)			8(yes)
9.Wounds heal slowly	0(no)			8(yes)
10.Your body or parts of your body feel tender, sore, sensitive to touch, hot and/or painful	0	1	4	8
11.Feel puffy and swollen all over your body	0	1	4	8
12.Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	0(no)			8(yes)

TOTAL POINTS:

PART IV - SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1.Sense of weakness	0	1	4	8
2.A sudden sense of anxiety when you get hungry	0	1	4	8
3.Tingling sensation in your hands	0	1	4	8
4.Sensation of heart beating too quickly or forcefully	0	1	4	8
5.Shaky, jittery, hands trembling	0	1	4	8
6.Sudden profuse sweating and/or skin feels clammy	0	1	4	8
7.Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8.Wake up at night feeling restless	0	1	4	8
9.Agitation, easily upset, nervous	0	1	4	8
10.Poor memory, forgetful	0	1	4	8
11.Confused or disorientated	0	1	4	8
12.Dizzy, faint	0	1	4	8
13.Cold or numb	0	1	4	8
14.Mild headaches or head pounding	0	1	4	8
15.Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

TOTAL POINTS:

PART IV - SECTION B

1.Frequent urination at night	0	1	4	8
2.Unusual thirst- feeling like you can't drink enough	0	1	4	8
3.Unusual hunger- eating all the time	0	1	4	8
4.Vision blurs	0	1	4	8
5.Feel itchy all over	0	1	4	8
6.Tingling or numbness in your feet	0	1	4	8
7.Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8.Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats) causes you to gain weight or prevents you from losing weight	0(no)			8(yes)
9.Sores heal slowly	0(no)			8(yes)
10.Loss of hair on your legs	0(no)			8(yes)

TOTAL POINTS:

PART V - SECTION A

1.Feel jittery	0	1	4	8
2.First effort of the day causes pain, pressure, tightness or heaviness around chest	0	1	4	8
3.Exhaustion with minor exertion	0	1	4	8
4.Heavy sweating (no exertion, hot flashes)	0	1	4	8
5.Difficulty catching breath, especially during exercise	0	1	4	8
6.Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7.Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

TOTAL POINTS:

PART V - SECTION B

1.Muslce pain at rest	0	1	4	8
2.Cramp-like pain in ankles, calves, or legs	0	1	4	8
3.Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4.Cold feet and/or toes appear blue	0	1	4	8
5.Brief moments of hearing loss	0	1	4	8
6.Nausea comes and goes quickly unrelated to eating	0	1	4	8
7.Feel worse standing: legs get heavy and fatigued	0	1	4	8
8.Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9.Fingers/ toes numb in cold even when protected	0	1	4	8
10.Notice changes in your ability to feel pain or discriminate sensations of hot or cold	0(no)			8(yes)
11.Body hair (on arms, hands, fingers, legs, toes) is thinning or has disappeared	0(no)			8(yes)
12.Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	0(no)			8(yes)

TOTAL POINTS:

PART VI - SECTION A

1.Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2.Do you cry?	0	1	4	8
3.Does life look entirely hopeless?	0	1	4	8
4.Would you describe yourself as feeling miserable and sad; unhappy and blue?	0	1	4	8
5.Do you find it hard to make the best of difficult situations?	0	1	4	8
6.Sleep problems - too much or too little	0	1	4	8
7.Changes in your appetite and weight	0(no)			8(yes)
8.Lately you've noticed an inability to think clearly or concentrate	0(no)			8(yes)
9.Difficulty making decisions and/or clarifying and achieving your goals	0(no)			8(yes)

TOTAL POINTS:

PART VI - SECTION B

1.Does worrying get you down?	0	1	4	8
2.Does every little thing get on your nerves and wear you out?	0	1	4	8
3.Would you consider yourself a nervous person?	0	1	4	8
4.Do you feel easily agitated?	0	1	4	8
5.Do you shake and tremble?	0	1	4	8
6.Are you keyed up and jittery?	0	1	4	8
7.Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8.Do you become scared at sudden movements or noises at night?	0	1	4	8
9.Do you find yourself sighing a lot?	0	1	4	8
10.Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11.Do frightening thoughts keep coming back in your mind?	0	1	4	8
12.Are you suddenly scared for no good reason?	0	1	4	8
13.Do you break out in a cold sweat?	0	1	4	8
14."Butterfles in you stomach", nausea and/or diarrhea	0	1	4	8

TOTAL POINTS:

PART VI - SECTION C

1.Do you feel pent up and ready to explode?	0	1	4	8
2.Are you prone to noisy and emotional outbursts?	0	1	4	8
3.Do you do things on impulse?	0	1	4	8
4.Are you easily upset or irritated?	0	1	4	8
5.Do you go to pieces if you don't control yourself?	0	1	4	8
6.Do little annoyances get on your nerves and make you angry?	0	1	4	8
7.Does it make you angry to have anyone tell you what to do?	0	1	4	8
8.Do you flare up in anger if you can't have what you want right away?	0	1	4	8

TOTAL POINTS:

PART VII

1.Eyes water or tear	0	1	4	8
2.Mucous discharge from the eyes	0	1	4	8
3.Ears ache, itch, feel congested or sore	0	1	4	8
4.Discharge from ears	0	1	4	8
5.Is your nose continually congested?	0	1	4	8
6.Are you prone to loud snoring?	0(no)			8(yes)
7.Does your nose run?	0	1	4	8
8.Nosebleeds	0(no)			8(yes)
9.Hoarse voice	0	1	4	8
10.Do you have to clear your throat?	0	1	4	8
11.Do you feel a choking lump in your throat?	0	1	4	8
12.Do you suffer from severe colds?	0(no)			8(yes)
13.Do frequent colds keep you miserable all winter?	0(no)			8(yes)
14.Flu symptoms last longer than 5 days	0(no)			8(yes)
15.Do infections settle in your lungs?	0(no)			8(yes)
16.Chest discomfort or pain	0	1	4	8
17.Do you experience sudden breathing difficulties?	0	1	4	8
18.Do you struggle with shortness of breath?	0	1	4	8
19.Difficulty exhaling (breathing out)	0	1	4	8
20.Breathlessness followed by coughing during exertion, no matter how slight.	0	1	4	8
21.Inability to breathe comfortably while laying down?	0	1	4	8
22.Do you cough up lots of phlegm?	0	1	4	8
23.Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24.Are you troubled with coughing?	0	1	4	8
25.Do you wheeze?	0	1	4	8
26.Do you have severe soaking sweats at night?	0	1	4	8
27.Do your lips and/or nails have a bluish hue?	0	1	4	8
28.Are you sleepy during the day?	0	1	4	8
29.Do you have difficulty concentrating?	0	1	4	8
30.Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products.	0	1	4	8
31.Eyes, ears, nose throat and lung symptoms are associated with seasonal changes.	0(no)			8(yes)
	0(no)			8(yes)

TOTAL POINTS:

PART VIII

1.Involuntary loss of urine when you cough, lift something or strain during an activity.	0	1	4	8
2.Mild lower back ache or pain	0	1	4	8
3.Abdominal achiness or pain	0	1	4	8
4.Pain or burning when urinating	0	1	4	8
5.Rarely feel the urge to urinate	0	1	4	8
6.Feel the need to urinate less than every two hours day or night	0	1	4	8
7.Strong smelling urine	0	1	4	8
8.Back or leg pains are associated with dripping after urination	0	1	4	8
9.Sore or painful genitals	0	1	4	8
10.Urine is a rose color	0	1	4	8
11.Sudden urge to void causes involuntary loss of urine	0	1	4	8
12.Generalized sense of water retention throughout your body	0	1	4	8

TOTAL POINTS:

PART IX - SECTION A

1.Bones throughout entire body ache, feel tender or sore	0	1	4	8
2.Localized bone pain	0	1	4	8
3.Hands, feet, throat get tight, spasm, or feel numb	0	1	4	8
4.Difficulty sitting straight	0	1	4	8
5.Upper back pain	0	1	4	8
6.Lower back pain	0	1	4	8
7.Pain when sitting down or walking	0	1	4	8
8.Find yourself limping or favoring one leg	0	1	4	8
9.Shins hurt during or after exercise	0	1	4	8

TOTAL POINTS:

PART IX - SECTION B

1.Are you stiff in the morning when you wake up?	0	1	4	8
2.Difficulty bending down and picking up clothing or anything from floor	0	1	4	8
3.Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees)	0	1	4	8
4.Joints hurt when moving or when carrying weight	0	1	4	8
5.A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6.Difficulty opening jars that were previously easy to open	0	1	4	8
7.Discomfort, numbness, prickling or tingling sensation or pain in neck, shoulder, arm	0	1	4	8
8.Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, neck and shoulders	0	1	4	8
9.Difficulty chewing food or opening mouth	0	1	4	8
10.Difficulty standing up from a sitting position	0	1	4	8
11.Shooting, aching, tingling pain down back of leg	0	1	4	8
12.Is it difficult to reach up and get a 5 pound object, like a bag of flour, from just above your head?	0(no)			8(yes)
13.Injure, strain or sprain easily?	0(no)			8(yes)

TOTAL POINTS:

PART IX - SECTION C

1.Muscles stiff, sore, tense and/or ache	0	1	4	8
2.Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3.Muscle cramps or spasms (involuntary, after exertion/exercise)	0	1	4	8
4.Is muscle pain or stiffness greater in the morning than other times of day?	0	1	4	8
5.Specific points on body feel sore when pressed.	0	1	4	8
6.Feel un-refreshed upon awakening	0	1	4	8
7.Headaches	0	1	4	8
8.Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9.Your jaw clicks or pops	0	1	4	8
10.Muscle twitch or tremor-eyelids, thumb, and calf muscle	0	1	4	8
11.Irresistible urge to move legs	0	1	4	8
12.Legs move during sleep	0	1	4	8
13.Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14.Hand and wrist numbness or pain (e.g. interferes with writing, buttoning or unbuttoning clothes)	0	1	4	8
15.Feeling of “pins & needles” in you thumb and first three fingers	0	1	4	8
16.Pain in forearm and sometimes shoulder	0	1	4	8

TOTAL POINTS:

PART X - SECTION A

1.Head feels heavy	0	1	4	8
2.Dizziness	0	1	4	8
3.Difficulty bending over, standing up from sitting, rolling over in bed, &/or turning head side to side	0	1	4	8
4.Your hands tremble, ever so slightly, for no reason	0	1	4	8
5.When walking you feel like you’re wearing heavy weights on your feet	0	1	4	8
6.Bump into things, trip, stumble and feel clumsy	0	1	4	8
7.Difficulty breathing	0	1	4	8
8.Difficulty swallowing	0	1	4	8
9.People say, “speak up” because they can’t hear you	0	1	4	8
10.Speaking & forming words does not feel automatic	0	1	4	8
11.Need 10-12 hours of sleep to feel rested	0	1	4	8
12.Lack strength (grip is weak, holding your head or picking your arms up takes effort)	0	1	4	8
13.Hands get tired when you write and your handwriting is less legible and smaller than it used to be	0(no)			8(yes)
14.Muscles in your arms & legs seem softer & smaller	0(no)			8(yes)
15.Is your vision, smell, taste & hearing not as sharp as it used to be?	0(no)			8(yes)
16. Do you find yourself moving slower than you use to?	0(no)			8(yes)

TOTAL POINTS:

PART X - SECTION B

1.Difficulty absorbing new information	0	1	4	8
2.Tend to forget things	0	1	4	8
3.Trouble thinking or concentrating	0	1	4	8
4.Easily distracted	0	1	4	8
5.Do you have a tendency to become frustrated quickly?	0	1	4	8
6.Inabilty to sit still for a length of time, even mealtime	0	1	4	8
7.Finishing tasks is easier said than done	0	1	4	8
8.Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9.Low tolerance for stress& otherwise ordinary problems	0	1	4	8

TOTAL POINTS:

PART XI

MEN ONLY

1.Sensation of not emptying your bladder completely	0	1	4	8
2.Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3.Find yourself needing to stop and start again several times while urinating	0	1	4	8
4.Find it difficult to postpone urination	0	1	4	8
5.Have a weak urinary stream	0	1	4	8
6.Need to push or strain to begin urinating	0	1	4	8
7.Dripping after urination	0	1	4	8
8.Urge to urinate several times a night	0	1	4	8

TOTAL POINTS:

PART XII- SECTION A

WOMEN ONLY

(Menopausal women skip to Section E & F)

Do you persistently experience any of these symptoms within three days to two weeks prior to menstruation? 0= No 8=Yes

[A]		
1.Anxious, irritable, or restless	0(no)	8(yes)
2.Numbness, tingling in hands & feet	0(no)	8(yes)
3. Easy to anger, resentful	0(no)	8(yes)
4. Aggressive or hostile toward family/friends	0(no)	8(yes)
[B]		
5.Abdominal bloating, feeling swollen (e.g. feet)	0(no)	8(yes)
6.Temporary weight gain	0(no)	8(yes)
7.Breat tenderness	0(no)	8(yes)
8.Appearance of breast lumps	0(no)	8(yes)
9.Discharge from nipples	0(no)	8(yes)
10.Nausea and/or vomiting	0(no)	8(yes)
11.Diarrhea or constipation	0(no)	8(yes)
12.Aches and pains (back, joints, etc)	0(no)	8(yes)
[C]		
13.Craving for sweets	0(no)	8(yes)
14.Increased appetite or binge eating	0(no)	8(yes)
15.Headaches	0(no)	8(yes)
16.Being easily overwhelmed, shaky or clumsy	0(no)	8(yes)
17.Heart pounding	0(no)	8(yes)
18.Dizziness or fainting	0(no)	8(yes)
[D]		
19.Confused & forgetful to the point that work suffers	0(no)	8(yes)
20.Overwhlemed with feelings of sadness & worthlessness	0(no)	8(yes)
21.Difficulty with sleeping or falling asleep	0(no)	8(yes)
22.Engaging in self destructive behavior	0(no)	8(yes)

TOTAL POINTS:

PART XII- SECTION B

WOMEN ONLY

(Menopausal women skip to Section E & F)

Do you experience any of these symptoms during your period?

1.Cramping in lower abdomen or pelvic area	0(no)	8(yes)
2.Pain is sharp &/or dull or intermittent	0(no)	8(yes)
3.Bloating and sense of abdominal fullness	0(no)	8(yes)
4.Diarrhea or constipation	0(no)	8(yes)

PART XII - SECTION B continued

5.Nausea and/or vomiting	0(no)	8(yes)
6.Low back and/or legs ache	0(no)	8(yes)
7.Headaches	0(no)	8(yes)
8.Unusaul fatigue (take naps) resulting in missed work	0(no)	8(yes)
9.Painful and/or swollen breasts	0(no)	8(yes)
10.Scanty blood flow	0(no)	8(yes)

TOTAL POINTS:

PART XII- SECTION C

WOMEN ONLY

(Menopausal women skip to Section E & F)

1.Painful or difficult sexual intercourse	0	1	4	8
2.Low abdominal, back and vaginal pain throughout the month	0	1	4	8
3.Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4.Vaginal bleeding other than during your period	0	1	4	8
5.Painful bowel movements	0	1	4	8
6.Difficult (straining) urination	0	1	4	8
7.Abnormal vaginal discharge	0	1	4	8
8.Offensive vaginal discharge	0	1	4	8
9.Vaginal itching or burning with or without intercourse	0	1	4	8
10.Pain during periods is getting progressively worse	0(no)			8(yes)
11.Profuse or prolonged menstrual bleeding	0(no)			8(yes)
12.Unable to get pregnant	0(no)			8(yes)

TOTAL POINTS:

PART XII- SECTION D

WOMEN ONLY

(Menopausal women skip to Section E & F)

1.Absence of periods for 6 months or longer	0(no)			8(yes)
2.Periods occur irregularly (e.g.,3-6 times a year)	0(no)			8(yes)
3.Profuse heavy bleeding during periods	0	1	4	8
4.Menstrual bleeding between periods can occur anytime	0	1	4	8
5.Bleeding between periods can occur anytime	0	1	4	8
6.Menstrual bleeding at cycles greater than every 35 days	0(no)			8(yes
7.Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of cycle)	0	1	4	8
8.Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9.Monthly abdominal pain without bleeding	0	1	4	8
10.Abundant cervical mucous	0	1	4	8
11.Acne and/or oily skin	0	1	4	8
12.Overwhelming urges for sexual intercourse	0	1	4	8
13.Aggressive feelings	0	1	4	8
14.Increased growth of dark facial and/or body hair	0(no)			8(yes)
15.Poor sense of smell	0(no)			8(yes)
16.Voice is becoming deeper	0(no)			8(yes)
17.Breasts seem to be getting smaller	0(no)			8(yes)
18.Receding hairline	0(no)			8(yes)

TOTAL POINTS:

PART XII- SECTION E: ***WOMEN ONLY***

1.Vaginal discharge	0	1	4	8
2.Vaginal secretions are watery and thin	0	1	4	8
3.Vaginal dryness	0	1	4	8
4.Sexual intercourse is uncomfortable	0	1	4	8
5.Interest in having sex is low	0	1	4	8
6.Engorged breasts	0	1	4	8
7.Breast tenderness, soreness	0	1	4	8
8.Difficulty with orgasm	0	1	4	8
9.Vaginal bleeding after sexual intercourse	0	1	4	8
10.Do you skip periods?	0(no)			8(yes)
11.The length of period varies month to month with the number of days of bleeding getting less	0(no)			8(yes)

TOTAL POINTS:

PART XII- SECTION F: ***WOMEN ONLY***

1.Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2.Sudden hot flashes	0	1	4	8
3.Spontaneous sweating	0	1	4	8
4.Chills	0	1	4	8
5.Cold hands and feet	0	1	4	8
6.Heart beats rapidly or feels like it is fluttering	0	1	4	8
7.Numbness, tingling or prickling sensations	0	1	4	8
8.Dizziness	0	1	4	8
9.Mental fogginess, forgetful, distracted	0	1	4	8
10.Inabilty to concentrate	0	1	4	8
11.Depression, anxiety, nervousness and/or irritability	0	1	4	8
12.Difficutly sleeping	0	1	4	8
13.Conscious of new feelings of anger & frustration	0	1	4	8
14.Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15.Stopped menstruating around 6 months ago, yet still experience some vaginal bleeding	0(no)			8(yes)

TOTAL POINTS:

Please mark an “X” to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area or above.