

(MEN)

CORNELL MEDICAL INDEX
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*.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, please guess.

A

1. Do you need glasses to read? Yes No
2. Do you need glasses to see things at a distance? Yes No
3. Has your eyesight often blacked out completely? Yes No
4. Do your eyes continually blink or water? Yes No
5. Do you often have bad pains in your eyes? Yes No
6. Are your eyes often red or inflamed? Yes No
7. Are you hard of hearing? Yes No
8. Have you ever had a bad running ear? Yes No
9. Do you have constant noises in your ears? Yes No

B

10. Do you have to clear your throat frequently? .. Yes No
11. Do you often feel a choking lump in your throat? Yes No
12. Are you often troubled with bad spells of sneezing? Yes No
13. Is your nose continually stuffed up? Yes No
14. Do you suffer from a constantly running nose? Yes No
15. Have you at times had bad nose bleeds? Yes No
16. Do you often catch severe colds? Yes No
17. Do you frequently suffer from heavy chest colds? Yes No
18. When you catch a cold, do you always have to go to bed? Yes No
19. Do frequent colds keep you miserable all winter? Yes No

20. Do you get hay fever? Yes No
21. Do you suffer from asthma? Yes No
22. Are you troubled by constant coughing? Yes No
23. Have you ever coughed up blood? Yes No
24. Do you sometimes have severe soaking sweats at night? Yes No
25. Have you ever had a chronic chest condition? Yes No
26. Have you ever had T.B. (Tuberculosis)? Yes No
27. Did you ever live with anyone who had T.B.? Yes No

C

28. Has a doctor ever said your blood pressure was too *high*? Yes No
29. Has a doctor ever said your blood pressure was too *low*? Yes No
30. Do you have pains in the heart or chest? Yes No
31. Are you often bothered by thumping of the heart? Yes No
32. Does your heart often race like mad? Yes No
33. Do you often have difficulty in breathing? Yes No
34. Do you get out of breath long before anyone else? Yes No
35. Do you sometimes get out of breath just sitting still? Yes No
36. Are your ankles often badly swollen? Yes No
37. Do you have cold hands or feet even in hot weather? Yes No
38. Do you suffer from frequent cramps in your legs? Yes No
39. Has a doctor ever said you had heart trouble? Yes No
40. Does heart trouble run in your family? Yes No

D

41. Have you lost more than half your teeth? Yes No
42. Are you troubled by bleeding gums? Yes No
43. Have you often had severe toothaches? Yes No
44. Is your tongue usually badly coated? Yes No
45. Is your appetite always poor? Yes No
46. Do you usually eat sweets or other food between meals? Yes No
47. Do you always gulp your food in a hurry? Yes No
48. Do you often suffer from an upset stomach? ... Yes No
49. Do you usually feel bloated after eating? Yes No
50. Do you usually belch a lot after eating? Yes No
51. Are you often sick to your stomach? Yes No
52. Do you suffer from indigestion? Yes No
53. Do severe pains in the stomach often double you up? Yes No
54. Do you suffer from constant stomach trouble? Yes No
55. Does stomach trouble run in your family? Yes No
56. Has a doctor ever said you had stomach ulcers? Yes No
57. Do you suffer from frequent loose bowel movements? Yes No
58. Have you ever had severe bloody diarrhea? ... Yes No
59. Were you ever troubled with intestinal worms? Yes No
60. Do you constantly suffer from bad constipation? Yes No
61. Have you ever had piles (rectal hemorrhoids)? Yes No
62. Have you ever had jaundice (yellow eyes and skin)? Yes No
63. Have you ever had serious liver or gall bladder trouble? Yes No

E

64. Are your joints often painfully swollen? Yes No
65. Do your muscles and joints constantly feel stiff? Yes No
66. Do you usually have severe pains in the arms or legs? Yes No
67. Are you crippled with severe rheumatism (arthritis)? Yes No
68. Does rheumatism (arthritis) run in your family? Yes No
69. Do weak or painful feet make your life miserable? Yes No

70. Do pains in the back make it hard for you to keep up with your work? Yes No
71. Are you troubled with a serious bodily disability or deformity? Yes No

F

72. Is your skin very sensitive or tender? Yes No
73. Do cuts in your skin usually stay open a long time? Yes No
74. Does your face often get badly flushed? Yes No
75. Do you sweat a great deal even in cold weather? Yes No
76. Are you often bothered by severe itching? Yes No
77. Does your skin often break out in a rash? Yes No
78. Are you often troubled with boils? Yes No

G

79. Do you suffer badly from frequent severe headaches? Yes No
80. Does pressure or pain in the head often make life miserable? Yes No
81. Are headaches common in your family? Yes No
82. Do you have hot or cold spells? Yes No
83. Do you often have spells of severe dizziness? Yes No
84. Do you frequently feel faint? Yes No
85. Have you fainted more than twice in your life? Yes No
86. Do you have constant numbness or tingling in any part of your body? Yes No
87. Was any part of your body ever paralyzed? Yes No
88. Were you ever knocked unconscious? Yes No
89. Have you at times had a twitching of the face, head or shoulders? Yes No
90. Did you ever have a fit or convulsion (epilepsy)? Yes No
91. Has anyone in your family ever had fits or convulsions (epilepsy)? Yes No
92. Do you bite your nails badly? Yes No
93. Are you troubled by stuttering or stammering? Yes No
94. Are you a sleep walker? Yes No
95. Are you a bed wetter? Yes No
96. Were you a bed wetter between the ages of 8 and 14? Yes No

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H

97. Have you ever had anything seriously wrong with your genitals (privates)? Yes No
98. Are your genitals often painful or sore? Yes No
99. Have you ever had treatment for your genitals? Yes No
100. Has a doctor ever said you had a hernia (rupture)? Yes No
101. Have you ever passed blood while urinating (passing water)? Yes No
102. Do you have trouble starting your stream when urinating? Yes No
103. Do you have to get up every night and urinate? Yes No
104. During the day, do you usually have to urinate frequently? Yes No
105. Do you often have severe burning pain when you urinate? Yes No
106. Do you sometimes lose control of your bladder? Yes No
107. Has a doctor ever said you had kidney or bladder disease? Yes No

I

108. Do you often get spells of complete exhaustion or fatigue? Yes No
109. Does working tire you out completely? Yes No
110. Do you usually get up tired and exhausted in the morning? Yes No
111. Does every little effort wear you out? Yes No
112. Are you constantly too tired and exhausted even to eat? Yes No
113. Do you suffer from severe nervous exhaustion? Yes No
114. Does nervous exhaustion run in your family? Yes No

J

115. Are you frequently ill? Yes No
116. Are you frequently confined to bed by illness? Yes No
117. Are you always in poor health? Yes No
118. Are you considered a sickly person? Yes No
119. Do you come from a sickly family? Yes No

120. Do severe pains and aches make it impossible for you to do your work? Yes No
121. Do you wear yourself out worrying about your health? Yes No
122. Are you always ill and unhappy? Yes No
123. Are you constantly made miserable by poor health? Yes No

K

124. Did you ever have scarlet fever? Yes No
125. As a child, did you have rheumatic fever, growing pains or twitching of the limbs? Yes No
126. Did you ever have malaria? Yes No
127. Were you ever treated for severe anemia (thin blood)? Yes No
128. Were you ever treated for "bad blood" (venereal disease)? Yes No
129. Do you have diabetes (sugar disease)? Yes No
130. Did a doctor ever say you had a goiter (in your neck)? Yes No
131. Did a doctor ever treat you for a tumor or cancer? Yes No
132. Do you suffer from any chronic disease? Yes No
133. Are you definitely *under* weight? Yes No
134. Are you definitely *over* weight? Yes No
135. Did a doctor ever say you had varicose veins (swollen veins) in your legs? Yes No
136. Did you ever have a serious operation? Yes No
137. Did you ever have a serious injury? Yes No
138. Do you often have small accidents or injuries? Yes No

L

139. Do you usually have great difficulty in falling asleep or staying asleep? Yes No
140. Do you find it impossible to take a regular rest period each day? Yes No
141. Do you find it impossible to do regular daily exercise? Yes No
142. Do you smoke more than 20 cigarettes a day? Yes No
143. Do you drink more than six cups of coffee or tea a day? Yes No
144. Do you usually take two or more alcoholic drinks a day? Yes No

M

145. Do you sweat or tremble a lot during examinations or questioning? Yes No
146. Do you get nervous and shaky when approached by a superior? Yes No
147. Does your work fall to pieces when the boss or a superior is watching you? Yes No
148. Does your thinking get completely mixed up when you have to do things quickly? Yes No
149. Must you do things very slowly in order to do them without mistakes? Yes No
150. Do you always get directions and orders wrong? Yes No
151. Do strange people or places make you afraid? Yes No
152. Are you scared to be alone when there are no friends near you? Yes No
153. Is it always hard for you to make up your mind? Yes No
154. Do you wish you always had someone at your side to advise you? Yes No
155. Are you considered a clumsy person? Yes No
156. Does it bother you to eat anywhere except in your home? Yes No

N

157. Do you feel alone and sad at a party? Yes No
158. Do you usually feel unhappy and depressed? Yes No
159. Do you often cry? Yes No
160. Are you always miserable and blue? Yes No
161. Does life look entirely hopeless? Yes No
162. Do you often wish you were dead and away from it all? Yes No

O

163. Does worrying continually get you down? Yes No
164. Does worrying run in your family? Yes No
165. Does every little thing get on your nerves and wear you out? Yes No
166. Are you considered a nervous person? Yes No
167. Does nervousness run in your family? Yes No
168. Did you ever have a nervous breakdown? ... Yes No
169. Did anyone in your family ever have a nervous breakdown? Yes No

170. Were you ever a patient in a *mental* hospital (for your nerves)? Yes No
171. Was anyone in your family ever a patient in a *mental* hospital (for their nerves)? Yes No

P

172. Are you extremely shy or sensitive? Yes No
173. Do you come from a shy or sensitive family? Yes No
174. Are your feelings easily hurt? Yes No
175. Does criticism always upset you? Yes No
176. Are you considered a touchy person? Yes No
177. Do people usually misunderstand you? Yes No

Q

178. Do you have to be on your guard even with friends? Yes No
179. Do you always do things on sudden impulse? Yes No
180. Are you easily upset or irritated? Yes No
181. Do you go to pieces if you don't constantly control yourself? Yes No
182. Do little annoyances get on your nerves and make you angry? Yes No
183. Does it make you angry to have anyone tell you what to do? Yes No
184. Do people often annoy and irritate you? Yes No
185. Do you flare up in anger if you can't have what you want right away? Yes No
186. Do you often get into a violent rage? Yes No

R

187. Do you often shake or tremble? Yes No
188. Are you constantly keyed up and jittery? Yes No
189. Do sudden noises make you jump or shake badly? Yes No
190. Do you tremble or feel weak whenever someone shouts at you? Yes No
191. Do you become scared at sudden movements or noises at night? Yes No
192. Are you often awakened out of your sleep by frightening dreams? Yes No
193. Do frightening thoughts keep coming back in your mind? Yes No
194. Do you often become suddenly scared for no good reason? Yes No
195. Do you often break out in a cold sweat? Yes No