HEALTH GOD

MASTER HEALTH ASSESSMENT

Questionnaire

Complete document and send to: info@healthgod.org

Date:_____

Please print clearly. Use a dark colored ink to ensure readability.

Personal Information

Name:_____ Ht.:_____in. Wt.:_____lbs. Age:_____

Male or Female:_____ Date of Birth: _____/_____/_____ Eye Color: _____

Address:_____ City:_____

State:_____ Zip Code: _____ Email: _____

Home Phone: (____)_____ Work Phone: (_____)_____ Fax: (_____)_____

Alt. / Cell Phone: (_____)_____ Skype: Y or N / Screen name:_____

Family Physician:_____,phone:(_____)_____

Other Provider:_____,phone:(_____)_____

Vitals Information

Blood Pressure: left side A _____/_____ right side A_____/_____

Pulse:_____ Respirations:_____ Basal Temperature:_____

PH:_____ Saliva:_____ Urine:_____

How many bowel movements do you have: per day _____

per week_____

What does your current diet consist of? :_____

_____

***If"there are any questions that you do not know. You may leave them blank.

THYROID/PARATHYROID (GLANDULAR SYSTEM)

YES ◯ NO ◯ Do you get cold hands and feet?
YES ◯ NO ◯ Is it easy to put on weight and hard to lose it?
YES ◯ NO ◯ Are your fingernails ridged, brittle or weak? (circle one)
YES ◯ NO ◯ Do you have varicose or spider veins?
YES ◯ NO ◯ Do you, or have you had hemorrhoids or prolapsed organs?(circle one)
YES ◯ NO ◯ Do you get cramping in your muscles?
strong ◯ weak ◯ Is your bladder strong or weak?
YES ◯ NO ◯ Do you have an irregular heartbeat?
YES ◯ NO ◯ Do you have Mitral Valve Prolaps (Heart Murmur)?
YES ◯ NO ◯ Do you get headaches or migraines?
YES ◯ NO ◯ Have you ever had a hernia?
YES ◯ NO ◯ Have you ever had an aneurysm?
YES ◯ NO ◯ Do you have osteoporosis?
YES ◯ NO ◯ Do you have scoliosis?
YES ◯ NO ◯ Do you get irritable easily?
YES ◯ NO ◯ Do you have low energy levels?
YES ◯ NO ◯ Do you suffer from symptoms of depression?
YES ◯ NO ◯ Did you score low on your bone density tests?
YES ◯ NO ◯ Do your tests come back showing low Calcium levels?
YES ◯ NO ◯ Do you have or have you ever had a goiter?
YES ◯ NO ◯ Do you have spine deterioration, herniated discs, or bone spurs?
YES ◯ NO ◯ Have you been diagnosed with Hashimoto or Reidel disease? Has a family member?
Low ◯ Med ◯ How much do you sweat?
Alot ◯
YES ◯ NO ◯ Do your legs get tired or cramp after you walk?
YES ◯ NO ◯ Do you bruise easily?(parathyroid)

PANCREAS

YES ◯ NO ◯ Do you get gas after you eat?
YES ◯ NO ◯ Do you feel your foods just sitting in your stomach?
YES ◯ NO ◯ Do you have Acid Reflux?
YES ◯ NO ◯ Do you see any undigested foods in your stools?
YES ◯ NO ◯ Are you thin and have a hard time putting on weight?
YES ◯ NO ◯ Do your foods pass right through you (diarrhea)?
YES ◯ NO ◯ Do you have moles on your body? (Adrenal & Pancreatic weakness)

ADRENAL GLANDS (GLANDULAR!SYSTEM)

Medulla(Adrenal)

YES ◯ NO ◯ Are you overweight?
YES ◯ NO ◯ Do you have M.S., Parkinson's or Palsy? (circle one)
YES ◯ NO ◯ Do you have anxiety attacks, or feel overly anxious?
YES ◯ NO ◯ Do you feel excessive shyness or inferior to others?
YES ◯ NO ◯ Do you have tremors, nervous legs, etc.?
YES ◯ NO ◯ Do you have High or Low Blood Pressure? (circle one)
Systolic_____ Diastolic_____
YES ◯ NO ◯ Do you have hypoglycemia (low blood sugar)?
YES ◯ NO ◯ Do you have Diabetes (high blood sugar)? If yes: TYPE I or TYPE II (circle one)
YES ◯ NO ◯ Do you have tinnitus (ringing in the ears)?
YES ◯ NO ◯ Do you have S.O.B. (shortness of breath) or is it hard to take a deep breath?
YES ◯ NO ◯ Do you have heart arrhythmias?
YES ◯ NO ◯ Do you have a hard time sleeping or insomnia?(pineal)
YES ◯ NO ◯ Do you have Chronic Fatigue Syndrome?
YES ◯ NO ◯ Have you ever been diagnosed with Addison's Disease or Congenital Adrenal Hyperplasia? (circle one)

Cortex (Adrenal)

YES ◯ NO ◯ Do you have elevated blood cholesterol levels?
YES ◯ NO ◯ Do you have arthritis, bursitis, or any inflammatory issues?
YES ◯ NO ◯ Do you have any "itis's" (inflammatory conditions)?
Which?_____
(arthritis,"bursitis,"rheumatoid"arthritis,"colitis,"enteritis,"phlebitis,"neuritis,"etc.)
YES ◯ NO ◯ Do you have low steroids or cortisol levels?

FEMALES ONLY

YES ◯ NO ◯ Are your menstruation's irregular?(pituitary)
YES ◯ NO ◯ Do you get excessive bleeding during menstruation?
YES ◯ NO ◯ Do you have or have you had ovarian cysts?
YES ◯ NO ◯ Do you have or have you had fibroids?
YES ◯ NO ◯ Do you have or have you had endometriosis or A typical cells?
YES ◯ NO ◯ Do you have or have you had fibrocystic breasts?
YES ◯ NO ◯ Do you get sore breasts, especially during menstruation?
YES ◯ NO ◯ Do you have a low or excessive sex drive?
YES ◯ NO ◯ Have you had a hysterectomy? Date:_____ Was it:
Partial_____ Complete_____
YES ◯ NO ◯ Did they take any other organs out at the same time?(ie: gallbladder) If yes, what other organs?_____
YES ◯ NO ◯ Have you had a D & C? If yes, date:_____
YES ◯ NO ◯ Have you had a miscarriage?
YES ◯ NO ◯ Have you had difficulty conceiving children?
YES ◯ NO ◯ Have you been on Birth Control Pills? For how long?_____
YES ◯ NO ◯ Are you currently pregnant?

MALES ONLY

YES ◯ NO ◯ Do you have prostatitis (frequent urination esp. at night)? If yes, how often do you urinate?: _____
YES ◯ NO ◯ Do you have prostate cancer?
What are your PSA counts?: _____ date: _____
YES ◯ NO ◯ Do you have testicular hypertrophy (enlargement)?
YES ◯ NO ◯ Do you have a low or excessive sex drive?
YES ◯ NO ◯ Do you have erection problems?
YES ◯ NO ◯ Do you have premature ejaculation?
Other:_____

GASTRO INTESTINAL TRACT

YES ◯ NO ◯ Do you have gastritis or enteritis?
YES ◯ NO ◯ Is your tongue coated (white, yellow, green or brown), especially in the morning?
YES ◯ NO ◯ Do you have gastroparesis?
YES ◯ NO ◯ Do you have a Hiatus Hernia?
YES ◯ NO ◯ Do you have Colitis?
YES ◯ NO ◯ Do you have Diverticulitis?
YES ◯ NO ◯ Do you get or have Diarrhea?
YES ◯ NO ◯ Do you get or have Constipation?

GASTRO INTESTINAL TRACT (continued)

YES ◯ NO ◯ Have you ever had stomach or intestinal ulcers?

YES ◯ NO ◯ Do you or have you had any type of gastro intestinal cancers?!(stomach, colon, rectal, etc.)
Explain:_____

YES ◯ NO ◯ Do you have Crohn's Disease?

YES ◯ NO ◯ Do you have "gas" problems?

Other GI problems:_____!

LIVER/GALLBALDDER/BLOOD

YES ◯ NO ◯ Do you have a problem digesting fats?

YES ◯ NO ◯ Do fats or dairy foods cause bloating and/or pain in the stomach area?

YES ◯ NO ◯ Are your stools white or very light brown in color?

YES ◯ NO ◯ Do you get pain in the middle of your back (especially after eating)?

YES ◯ NO ◯ Do you get pain behind the right, lower rib area?

YES ◯ NO ◯ Do you have "liver" or brown spots on your skin? (not freckles)

YES ◯ NO ◯ Are you Janudiced (yellowing of the skin)?

YES ◯ NO ◯ Do you have any skin pigmentation changes?

YES ◯ NO ◯ Are you or have you ever been anemic?

YES ◯ NO ◯ Do you have, or have you ever had, hepatitis? If so: A_____,B_____,C_____.

HEART AND CIRCULATION

YES ◯ NO ◯ Do you get chest pains or angina?

YES ◯ NO ◯ Have you ever had a heart attack (Myocardial Infarction)?

YES ◯ NO ◯ Have you ever had open heart surgery?

YES ◯ NO ◯ Do you have heart arrhythmia's?
What kind?

YES ◯ NO ◯ Do you have a heart murmur or Mitral Valve Prolapse?

YES ◯ NO ◯ Do you ever feel pressure on your chest?

YES ◯ NO ◯ Do you get "prickly" pains anywhere, especially in the heart area?
Where? _____

YES ◯ NO ◯ Do you have, or have you ever had High Blood Pressure? (kidneys)

YES ◯ NO ◯ Do you have a Pacemaker or Stints? (circle one)

SKIN

YES ◯ NO ◯ Do you get or have skin rashes?
YES ◯ NO ◯ Do you get skin blemishes?
YES ◯ NO ◯ Do you have Eczema or Dermatitis?
YES ◯ NO ◯ Do you have Psoriasis?
YES ◯ NO ◯ Do you itch anywhere? Where?
YES ◯ NO ◯ Is your skin dry?
YES ◯ NO ◯ Is your skin excessively oily?
YES ◯ NO ◯ Do you get or have dandruff?
YES ◯ NO ◯ Do you have skin problems? If so, what type?: _____

LYMPHATIC SYSTEM

YES ◯ NO ◯ Do you have hair loss or are you bald or going bald?
YES ◯ NO ◯ Have you ever had Lymph Nodes removed?
YES ◯ NO ◯ Do you have, or have you ever had, a goiter?
YES ◯ NO ◯ Do you have any gray hair?
YES ◯ NO ◯ Do you have a hard time remembering things?
YES ◯ NO ◯ Do you ever get colds or flu like symptoms?
YES ◯ NO ◯ Do you have fibromyalgia or scleroderma?
YES ◯ NO ◯ Do you have sinus problems?
YES ◯ NO ◯ Do you have or get sore throats?
YES ◯ NO ◯ Do you have swollen lymph nodes?
YES ◯ NO ◯ Do you have or have you had tumors? If so, Where?:
_____ Type (circle one):
Fatty Benign Malignant
YES ◯ NO ◯ Do you have a low platelet count (blood)?
YES ◯ NO ◯ Is your immune system weak or sluggish?
YES ◯ NO ◯ Have you had appendicitis or an appendectomy? When?_____
YES ◯ NO ◯ Do you get boils, pimples, cysts, etc.?
YES ◯ NO ◯ Do you get regular exercise? How many times per week? _____
YES ◯ NO ◯ Have you ever had abscesses?
YES ◯ NO ◯ Have you ever had toxemia?
YES ◯ NO ◯ Do you have, or have you had, cellulitis?
YES ◯ NO ◯ Have you ever had gout?
YES ◯ NO ◯ Do you get blurred vision?
YES ◯ NO ◯ Do you have mucus in your eyes when you wake up in the morning?
YES ◯ NO ◯ Do you snore?
YES ◯ NO ◯ Do you have sleep apnea?
YES ◯ NO ◯ Have you had your tonsils out? _____ What age?_____

KIDNEYS AND BLADDER

YES ◯ NO ◯ Have you ever had a urinary tract infection (UTI's)?
YES ◯ NO ◯ Have you ever had "burning" upon urination?
YES ◯ NO ◯ Do you have problems holding your bladder? (parathyroid)
YES ◯ NO ◯ Have you ever had kidney stones?
YES ◯ NO ◯ Do you have bags under your eyes (esp. in the morning)?
YES ◯ NO ◯ Is your urine flow restricted?
YES ◯ NO ◯ Do you get cramping or pain on either side of your mid to lower back?
YES ◯ NO ◯ Do you or did you ever have nephritis?
YES ◯ NO ◯ Do you have lower back weakness?
YES ◯ NO ◯ Do you have or have you had sciatica?
YES ◯ NO ◯ Do you or did you ever have cystitis?

LUNGS

YES ◯ NO ◯ Do you get or have (or have had) bronchitis?
YES ◯ NO ◯ Do you get or have (or have had) emphysema?
YES ◯ NO ◯ Do you get or have (or have had) asthma?
YES ◯ NO ◯ Do you get or have (or have had) C.O.P.D?
YES ◯ NO ◯ Are you on inhalers or nebulizers? How often?_____ What type? _____ Your oxygen saturation level is _____.
YES ◯ NO ◯ Do you get pain when you breathe?
YES ◯ NO ◯ Do you get pain when you take a deep breath? (adrenals)
YES ◯ NO ◯ Is it difficult to take a deep breath?
YES ◯ NO ◯ Did you ever or do you have lung cancer?
YES ◯ NO ◯ Do you have a collapsed lung?
YES ◯ NO ◯ Are you a smoker? How often? _____ Packs per day OR _____cigarettes per day
YES ◯ NO ◯ Have you ever had pneumonia?
YES ◯ NO ◯ Have you ever worked around toxic chemicals, in coal mines or around asbestos?
YES ◯ NO ◯ Do you cough a lot?
YES ◯ NO ◯ Do you get any mucus when you cough?
YES ◯ NO ◯ What color is the mucus? (clear, yellow, green, brown or black?)

ENVIRONMENTAL TOXINS

YES ◯ NO ◯ Have you been vaccinated?
YES ◯ NO ◯ Have you had shots for traveling to foreign countries?
YES ◯ NO ◯ Have you had Flu shots?
YES ◯ NO ◯ Do you have mercury Amalgams?
YES ◯ NO ◯ Do you find it difficult to take deep breaths?
YES ◯ NO ◯ Have you been exposed to nuclear wastes or byproducts, heavy metals or chemicals?
YES ◯ NO ◯ Have you had radiation or chemotherapy? (circle one)
If so, how many treatments?_____

CHEMICAL MEDICATIONS *(List any chemical medications that you are presently taking)*

Medication Name	**Purpose for taking**

NATURAL SUPPLEMENTS *(List any natural supplements you are currently taking)*

Supplement

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES *(Listanythingthat youareallergicto)*

_____

_____

_____

_____

_____

_____

_____

PAST SURGERIES *(List any past surgeries you have had, minor and major and the year)*

1)_____ 7) _____

2)_____ 8) _____

3)_____ 9) _____

4)_____ 10) _____

5) _____ 11) _____

6) _____ 12) _____

GENETIC/FAMILY MEDICAL HISTORY *(List the health issues each family member had)*

Mother:
Father:
(Maternal)!Grandfather:
(Maternal)!Grandmother:
(Paternal)!Grandfather:
(Paternal)!Grandmother:
Sister:
Sister:
Brother:
Brother:

WHAT ARE YOUR MAJOR HEALTH COMPLAINTS OR CONCERNS?

Please list any conditions or symptoms that were not covered in this questionnaire.

SUBMIT