Rate your ability to work (please circle) 0 1 2 3 4 5 6 7 8 9 10

No effect **Moderate restriction** **Cannot do any work**

Rate your ability to do housework 0 1 2 3 4 5 6 7 8 9 10

No effect **Moderate restriction** **Cannot do any work**

==========

Have you ever currently, or in the past had:

(please circle) How long / How often

Current / Past **Headaches**: _____

Current / Past **Dizziness**: _____

Current / Past **Fainting**: _____

Current / Past **Ringing Ears**: _____

Current / Past **Ear Pain**: _____

Current / Past **Jaw Pain or Noise**: _____

Current / Past **Grinding Teeth**: _____

Current / Past **Stomach Pain**: _____

Current / Past **Shortness of Breath**: _____

Current / Past **Pain/Tightness in Chest**: _____

Current / Past **Weakness in Arms or Legs**: _____

Current / Past **Urinary Issues**: _____

In the past year, have you had any problems with your (please circle)**:**

Head If yes, what kind? _____

Neck If yes, what kind? _____

Shoulder If yes, what kind? _____

Elbows If yes, what kind? _____

Wrists If yes, what kind? _____

Upper Back If yes, what kind? _____

Middle Back If yes, what kind? _____

Lower Back If yes, what kind? _____

Hips If yes, what kind? _____

Knees If yes, what kind? _____

Ankles If yes, what kind? _____

Feet If yes, what kind? _____

Heart If yes, what kind? _____

Lungs If yes, what kind? _____

Stomach If yes, what kind? _____

Liver If yes, what kind? _____

Pancreas If yes, what kind? _____

Gallbladder If yes, what kind? _____

Kidneys If yes, what kind? _____