Dr. Oak's Health Questionnaire

Name: _____ Date:_____

Age:_____ Sex: Male / Female Height:_____ Weight: _____

History:

Chief Complaint: (What brings you to the doctor today?)

_____

For a specific pain or problem:

Where is it?_____ Does anything relieve it?_____

How long have you had it?_____ Have you treated it?_____

Have you had any testing (CT scans, x-rays, dopplers):_____

Drug Allergies?: _____Yes _____No (if yes please list reaction):_____

_____

Medications (Please list all medication, including over the counter meds):_____

_____

_____

_____

Surgical History:

Please list all surgeries/operations: _____

_____

Family History:

Has anyone in your family had the following, if so list who had this history

Diabetes_____, Heart Disease_____, Stroke_____, High blood pressure_____, Cancer_____

Kidney disease_____, Vascular disease (blood vessels)_____

Social History:

What is your occupation:_____ full time/ part time/ retired.

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Use of alcohol: How many drinks: _____ daily/weekly/monthly/never

Use of tobacco: Never_____ Currently smoking_____ (pkgs per day) Previously, but quit:_____

Medical History/Review of Systems:

Constitutional			**Musculoskeletal**			
Fever	y	N	Back pain	Y	N	
Chills	Y	N	Osteoporosis	Y	N	
Nightsweats	Y	N	Arthritis	Y	N	
Psychiatric			Joint pain	Y	N	
Depression	Y	N	Fractures	Y	N	location:_____
Sleep disorder	Y	N	other ortho problems:	_____		

Name:_____

Cardiovascular

Heart attack	Y	N
Heart failure	Y	N
Heart murmur	Y	N
Mitral valve Prolapse	Y	N
High blood pressure	Y	N
Stroke/TIA	Y	N
Irregular heart beat	Y	N
Aneurysm	Y	N
Poor leg circulation	Y	N
Varicose veins	Y	N
Raynaud's disease	Y	N

Respiratory

Pneumonia	y	N
Asthma	Y	N
Emphysema	Y	N
Bronchitis	Y	N
Tuberculosis	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Stomach ulcers	Y	N
Irritable bowel	Y	N
Blood in stools	Y	N

Hematoloy/lymphatic

Anemia	Y	N
Blood Clots	Y	N
Enlarged lymph nodes	Y	N
Leg swelling	Y	N
Lupus	Y	N

Allergies/Immunology

AIDS/HIV	Y	N	
Hepatitis	Y	N	type A/B /C

Integumentary/Skin/Breast

Skin rashes	Y	N	location:_____
Non-healing sore/ulcer	Y	N	location:_____
Breast lump/discharge	Y	N	

Neurological

Dizzy spells	Y	N
Seizure/convulsions	Y	N
Headaches	Y	N
Head injury	Y	N
Multiple Sclerosis	Y	N

Eyes/ENT

Visual changes	Y	N	describe_____
glaucoma/cataracts	Y	N	
loss of hearing	Y	N	
Sinus problems	Y	N	
Seasonal Allergies	Y	N	

Endocrine

Diabetes	Y	N	type: adult/juvenile
			Insulin dependent/non-insulin dependent
Thyroid problems	Y	N	hyper/hypo
Gout	Y	N	

Renal Disease

Kidney failure	Y	N
Bladder infections	Y	N
Kidney stones	Y	N

History of Cancer

Do you have a personal history of cancer

What type:_____

DIALYSIS CENTER_____

Vascular Patients

Do you have leg pain Y N

If yes to pain, cramps or tiredness in legs or thighs, please answer yes or no below:

_____ Does it limit work/lifestyle? **_____Does pain go away if you rest for a few minutes?**

_____ State distance you can walk before you have pain

_____ Does pain make you stop walking? **_____ Do you have pain at rest**