

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

Fever y N

Chills Y N

Nightsweats Y N

Psychiatric

Depression Y N

Sleep disorder Y N

Musculoskeletal

Back pain Y N

Osteoporosis Y N

Arthritis Y N

Joint pain Y N

Fractures Y N location: _____

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

Hematology/lymphatic

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

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

Allergies/Immunology

AIDS/HIV	Y	N
Hepatitis	Y	N

type A/B /C

Integumentary/Skin/Breast

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

location: _____

location: _____

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

describe _____

Endocrine

Diabetes	Y	N
Insulin dependent/non-insulin dependent		
Thyroid problems	Y	N
Gout	Y	N

type: adult/juvenile

hyper/hypo

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 _____

_____ Does pain make you stop walking?

_____ Do you have pain at rest