OAKLEAF CLINICS S.C.
PATIENT QUESTIONNAIRE
Please complete the form using black ink

Today's Date ____________ Do you have a medical advanced directive on file? ____________

Patient's Name ____________ **Birth Date** ____________

PERSONAL MEDICAL HISTORY: Please indicate **PAST** or **PRESENT** for those that are applicable.

Diabetes ____ Heart Condition ____ Hemorrhoids ____ Thyroid Condition ____
Asthma ____ Eating Disorder ____ Gastric Reflux Disease ____ Anxiety ____
High Blood Pressure ____ Blood Transfusion ____ IBS ____ Depression ____
Other ____ Cancer ____ Blood Clots ____ Date of last Tetanus ____

SURGICAL HISTORY: Have you had any of the following surgeries? Mark yes or no. Give dates if known.

Tonsillectomy ____ Tubal Ligation ____ Appendectomy ____
Hysterectomy ____ Gallbladder ____ D & C ____
Kidney ____ Bladder ____ C-Section ____
Cervical Cryosurgery/LEEP ____ Colonoscopy ____ Other Surgeries ____

ALLERGIES AND REACTION:

Drugs: ____________
Food: ____________ Other ____________

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS:

List of medications including the dosage ____________

CURRENT HEALTH PRACTICES:

Check any one of the following habits that may apply and list the average amount consumed per **DAY** or per **WEEK**.

☐ Alcohol (beer, wine, hard liquor) Amount ____ ☐ Caffeine (coffee, tea, soda) Amount ____
☐ Recreational drug use: ☐ Yes ☐ No If yes, type ____
☐ Tobacco: Type ____ Age started ____ Average Daily Amount ____
Still smoking? ☐ Yes ☐ No If no, how long did you smoke? ____
Would you like assistance in quitting? ☐ Yes ☐ No

Check the word that applies to your use of seat belts: ☐ Always ☐ Sometimes ☐ Never
Do you exercise regularly? ☐ Yes ☐ No If yes, type of exercise ____
If you are on a special diet, describe ____
Describe your calcium intake and the amount that you consume ____
Frequency of dental checkup: ____ Frequency of eye exam: ____
Do you feel safe in your relationship with your partner? (yes or no) ____
Sunscreen Use? (yes or no) ____

MENSTRUAL HISTORY: (Women Only)

Age of first menstruation ____ Menopause: Yes ____ No ____ When ____
Number of days your period usually lasts ____
Number of days from 1st day of one period to the 1st day of the next ____
# of pregnancies ____ #of children ____ Miscarriages ____ Abortions ____
First day of last menstrual period (date) ____ Last pap smear (date) ____
History of abnormal pap smear(s) Yes ____ No ____ (date) ____
Method of Birth Control (please circle) Pills Patch Condoms IUD Ring Depo Provera Nexplanon, Natural Family Planning, Tubal Ligation, Vasectomy, None Other ____
Does natural mother or sister have history of breast or ovarian cancer? Yes ____ No ____

FAMILY HISTORY: List which family member had what condition. Include natural parents, siblings, grandparents, aunts, uncles, and children. Please note the age of onset, if known, and whether it is **Mom's Side (Maternal)** or **Dad's Side (Paternal)**.

Heart Disease ____ Alcoholism ____ Thyroid Problems ____
High Blood Pressure ____ Depression ____ Cancer & Type ____
Stroke ____ Diabetes ____ ____
Other ____

(over)

REVIEW OF SYSTEMS:

CONSTITUTIONAL	Yes	No	History of
Fever	______	______	______
Chills	______	______	______
Fatigue	______	______	______
Loss of Appetite	______	______	______
Recent Weight Changes	______	______	______
Malaise-just not feeling right	______	______	______
HEAD & FACE			
Facial Pain	______	______	______
Facial Pressure	______	______	______
EYE, EAR, NOSE & THROAT			
Eye pain	______	______	______
Red, Itchy Eyes	______	______	______
Blurred or Double Vision	______	______	______
Eye Drainage	______	______	______
Loss of Hearing	______	______	______
Nasal Congestion or Discharge	______	______	______
Sore or Scratchy Throat	______	______	______
Hoarseness	______	______	______
White Patches in Mouth	______	______	______
CARDIOVASCULAR			
Palpitations	______	______	______
Chest pain	______	______	______
Ankle Swelling	______	______	______
Racing Heart	______	______	______
Lightheadedness	______	______	______
RESPIRATORY			
Recent Cough - dry	______	______	______
Shortness of Breath with Activity	______	______	______
Wheezing or Asthma	______	______	______
Pulmonary emboli (blood clot to the lung)	______	______	______
Sleeping Upright/Extra Pillows	______	______	______
GASTROINTESTINAL			
Heartburn	______	______	______
Abdominal pain	______	______	______
Nausea or Vomiting	______	______	______
Bloating or Food Intolerances	______	______	______
Diarrhea	______	______	______
Constipation	______	______	______
Black Tarry Stool	______	______	______
Unable to pass flatus (gas)	______	______	______
Rectal Bleeding	______	______	______
GENITOURINARY			
Do you get up at night to urinate?	______	______	______
Pain or burning with urination	______	______	______
Difficulty starting or holding urine	______	______	______
Blood in the urine	______	______	______
Dark Urine	______	______	______
Flank (side) Pain	______	______	______

GENITOURINARY (cont.)	Yes	No	History of
Genital Warts	______	______	______
Gonorrhea, Syphilis, or Chlamydia	______	______	______
Genital Herpes	______	______	______
Pain or other problems with intercourse	______	______	______
Possibly Pregnant	______	______	______
Change in Menstrual Pattern	______	______	______
Disabling Menstrual Cramps	______	______	______
Unusual Vaginal discharge or bleeding	______	______	______
Pelvic Pain	______	______	______
Other (describe)			

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MUSCULOSKELETAL	Yes	No	History of
Back Pain/Back Muscle Spasm	______	______	______
Joint Problems, Swelling, Stiffness	______	______	______
Muscle Aches/Limping	______	______	______
INTEGUMENTARY AND BREASTS			
Lumps	______	______	______
Tenderness	______	______	______
Drainage from Nipple	______	______	______
Monthly Breast self-examination	______	______	______
Rash, Lesions, Wounds	______	______	______
NEUROLOGICAL			
Headache	______	______	______
Migraine Headaches	______	______	______
Confusion	______	______	______
Dizziness	______	______	______
Fainting	______	______	______
Numbness	______	______	______
Tingling	______	______	______
Leg Weakness	______	______	______
Difficulty Walking	______	______	______
PSYCHIATRIC			
Insomnia	______	______	______
Irritable	______	______	______
Anxiety	______	______	______
Depression	______	______	______
Suicidal	______	______	______
ENDOCRINE			
Hot Flashes	______	______	______
Night Sweats	______	______	______
Weakness	______	______	______
HEMATOLOGIC AND LYMPHATIC			
Swollen Glands	______	______	______
Easy Bruising	______	______	______
Easy Bleeding	______	______	______
Jaundice	______	______	______

Please list your main concern for today's visit ____

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