OSCAR N. ABELIUK, M.D.
NEUROLOGIST

Name_____Date_____

Social Security #_____

PATIENT QUESTIONNAIRE

Please fill out this sheet as carefully as you can. **TRY TO ANSWER ALL THE QUESTIONS** that apply to you. The more complete the information you supply, the better your doctor will be able to understand your problem and help you.

You may use the back side of any page to explain your answers or to give more information. Some questions are of a personal nature; they are intended only to assist the doctor in assessing your problem.

Who referred you to this office?_____

Name of Internist/Family Physician_____

REASON FOR THIS VISIT

Please list the main symptoms for which you were referred to this office.

_____

_____

_____

_____

Is this condition due to a work-related accident or personal injury? *YES____* *NO____*
If *yes*, please describe your injury ***in detail*** in your own words:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Employer at the time of the injury:

_____

Date hired: _____
Job title when injured: _____

Were you working at any *other* job at the time of your injury?_____

_____

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PRESENT COMPLAINTS

Describe in order, beginning with what bothers you the *most.* Please explain *in detail.*

(Please use the back of the page if you need more space)

List below any treatments, hospitalizations, medications that you have had in connection with your current problem. List the names of all the physicians and doctors who have treated you, or with whom you have consulted.

How much time (give dates) have you missed from work due to your current problem? Explain.

Were any symptoms noted during prior or subsequent employment? Explain

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PERSONAL INFORMATION

Age:_____ Sex: M F (circle) Married___ Single___ Divorced___ Separated___ Widowed___

Place of birth:_____ Highest grade completed_____ Occupation:_____

Height_____ Current Weight_____ Weight one year ago_____ Maximum weight_____ When_____

Are you pregnant? (Y/N) _____ Right handed ____ Left handed ____

Do you smoke? (Y/N) _____ How many packs/day? _____

Do you drink (Y/N) _____ Drinks per day_____ per week _____

Are you on a special diet? Yes _____ No _____ Type:_____

NON-WORK ACTIVITIES

Arts/crafts_____ Tennis_____ Golf_____ Skiing_____ Bowling_____ Fishing_____ Hunting_____
Camping_____ Running_____ Hiking_____ Travel_____ Reading_____ Movies_____ Auto Repair____
Spectator Sports_____ Shopping_____ Gardening_____ Housework_____ TV_____

STRESS FACTORS

Job	low___	medium___	high___
Financial	low___	medium___	high___
Personal	low___	medium___	high___
Marital	low___	medium___	high___

MILITARY SERVICE

Dates of military service, if any: From_____ To:_____
Branch_____of_____ Service_____
Assignment_____

Where were you stationed?_____

Do you have any service-connected disability? Yes_____ No_____

Explain_____
_____

Give details of any illnesses and medical treatment you had while in the service:
_____
_____
_____

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PAST MEDICAL HISTORY

PAST HOSPITALIZATIONS: **No previous hospitalizations_____**

List any past hospitalizations for illness or surgery. Include minor surgeries.

APPROX. DATE	REASON	TREATMENT	HOSPITAL/CITY	DOCTOR

PAST ILLNESSES FOR WHICH YOU WERE NOT HOSPITALIZED: **No serious illnesses_____**

AGE	APPROX. DATE	ILLNESS

CHILDHOOD DISEASES

AGE	APPROX. DATE	DISEASE

NON WORK-RELATED ACCIDENTS & INJURIES (INCLUDING AUTO ACCIDENTS)

No previous accidents_____

APPROX. DATE	TYPE OF ACCIDENT	INJURIES

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CURRENT MEDICATIONS:

NAME OF MEDICINE	REASON FOR TAKING	LENGTH OF TIME TAKEN

Are you allergic to any medications? **No known medication allergies____**

NAME OF MEDICINE	TYPE OF REACTION

Previous Tests:

CT of head____ CT of back____ MRI of head____ MRI of neck____ X-Ray of head____ Myelogram____

X-ray of neck____ X-Ray of back____ EEG (brain waves)____ EMG (nerve test)____ Discogram____

Current physicians *OTHER THAN YOUR INTERNIST OR FAMILY PHYSICIAN:*

NAME OF PHYSICIAN	SPECIALTY	CITY

FAMILY HISTORY

Relative	If Living		If Deceased		Has Any Blood Relative Had:	
	Age	Health	Age	Cause		Y/N
Father					Arthritis	
Mother					Tuberculosis	
Siblings					Diabetes	
1					Heart Disease	
2					High Blood Pressure	
3					Stroke	
4					Mental Illness	
5					Suicide	
6						
Spouse						
Children						
1						
2						
3						
4						
5						
6						

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Place a check mark in the appropriate squares in the following lists of symptoms.
If you have had a symptom in the past, and do not have it now, check square like this: √ ☐

If you are having the symptom at the present time, encircle the square like this: ◯

1. HEAD AND NECK

	Yes	No
SEVERE HEADACHES?	☐	☐
DIZZY SPELLS?	☐	☐
FAILING VISION?	☐	☐
EYE PAIN?	☐	☐
DOUBLE VISION?	☐	☐
SWELLINGS IN NECK?	☐	☐
SEVERE HEARING LOSS?	☐	☐
RINGING IN EARS?	☐	☐
PAIN IN EARS?	☐	☐
DISCHARGE FROM EAR?	☐	☐
REPEATED NOSEBLEEDS?	☐	☐
TOOTHACHE AT PRESENT?	☐	☐
CHRONIC NOSE OBSTRUCTION?	☐	☐
CHRONIC SORE TONGUE?	☐	☐
PERSISTENT SORE GUMS?	☐	☐
PROLONGED HOARSENESS?	☐	☐
PERSISTENT NECK RIGIDITY?	☐	☐
SEE "FLOATING LIGHTS"?	☐	☐

2. HEART AND LUNGS

	Yes	No
CHEST PAIN ON EFFORT?	☐	☐
SKIPPING HEART BEATS?	☐	☐
DIFFICULT BREATHING?	☐	☐
SIT UP TO BREATHE EASY?	☐	☐
HAVE CHRONIC COUGH?	☐	☐
SPIT UP BLOOD?	☐	☐
HAVE NIGHT SWEATS?	☐	☐
ANKLES SWELL?	☐	☐
ANY HEART DEFECTS?	☐	☐

3. STOMACH AND INTESTINES

	Yes	No
CHRONIC ABDOMINAL PAIN?	☐	☐
PERSISTENT NAUSEA?	☐	☐
HEART BURN?	☐	☐
APPETITE LOSS?	☐	☐
VOMIT BLOOD?	☐	☐
SKIN TURN YELLOW?	☐	☐
ANY CHRONIC DIARRHEA?	☐	☐
ANY BLACK TARRY STOOLS?	☐	☐
ANY BLOOD FROM RECTUM?	☐	☐
CLAY-COLORED STOOLS?	☐	☐
HABITUAL CONSTIPATION?	☐	☐
HAVE HEMORRHOIDS?	☐	☐

4. URINARY TRACT - ETC.

	Yes	No
ANY EXCESS URINATION?	☐	☐
ANY URINARY SHUTDOWN?	☐	☐
SCANTY URINATION?	☐	☐
ANY BLOOD IN URINE?	☐	☐
EXCESS NIGHT URINATION?	☐	☐
PAIN WITH URINATION?	☐	☐
ANY LEAKAGE OF URINE?	☐	☐
PASSED ANY STONES?	☐	☐
ANY BEDWETTING?	☐	☐
ANY RETENTION OF URINE?	☐	☐

(For Women Only)

	Yes	No
PAINFUL MENSTRUATION?	☐	☐
EXCESS MENSTRUATION?	☐	☐
BLEED BETWEEN PERIODS?	☐	☐
ANY MISSED PERIODS?	☐	☐

NUMBER OF PREGNANCIES ____
NUMBER OF LIVING CHILDREN ____

5. MUSCLES - JOINTS - NERVES

	Yes	No
ANY TINGLING SENSATIONS?	☐	☐
ANY NUMBNESS?	☐	☐
DISTURBANCE IN WALKING?	☐	☐
ANY MUSCLE JERKING?	☐	☐
ANY PARALYSIS?	☐	☐
ANY SHAKING?	☐	☐
ANY LIMITED MOTIONS?	☐	☐
ANY JOINT TROUBLE?	☐	☐
NERVOUS BREAKDOWN?	☐	☐
ANY STROKES?	☐	☐
ANY MEMORY LOSS?	☐	☐
PERSONALITY CHANGES?	☐	☐
SPEECH DISTURBANCES?	☐	☐
ANY SEIZURES?	☐	☐
ANY ALCOHOL PROBLEM?	☐	☐
ANY DRUG PROBLEM?	☐	☐
ANY MENTAL PROBLEM?	☐	☐
ANY VARICOSE VEINS?	☐	☐

6. ALLERGIES

	Yes	No
ANY FOOD ALLERGY?	☐	☐
ANY MEDICATION ALLERGY?	☐	☐
INHALATION ALLERGY?	☐	☐
ANY CONTACT ALLERGY?	☐	☐
ADHESIVE TAPE ALLERGY?	☐	☐
SUBJECT TO SKIN RASH?	☐	☐

IF THERE ARE ANY FOOD OR MEDICATION ALLERGIES, LIST HERE WHAT THEY ARE:

If there are any additional health factors in your history, or if any of the above points need clarifying, use this space for additional comments: _____

_____

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OCCUPATIONAL HISTORY

All of these questions are directed to the position you had at the time of your injury. If you have since transferred or changed jobs, please answer for the job at the time you were injured.

Name of Employer				
Job Title at time of injury				
Activity	**Time Spent**			
	None at all	Up to 1/3 of Workday	Up to 2/3 of Workday	More than 2/3 of Workday
Sitting				
Standing				
Bending				
Lifting between 0-15 lbs				
between 15-40 lbs				
between 40-80 lbs				
Lifting overhead				
Squatting				
Climbing				
Kneeling				
Twisting (your torso or lower back)				
Walking				
Walking on uneven terrain				
Simple (or light) grasping with hands				
Fine manipulative hand motions (e.g. circuit board work, typing, etc.)				
Pushing and pulling				
Reaching overhead				
Use of foot controls				

Please estimate the maximum lifting requirements of your job at the time you were injured..

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Do you do any of the following activities?			
	Yes	No	
Driving			
Walking			
Cooking			

Can you	Normal	Limited	Not at all
Bend			
Stoop			
Walk*			
Sit*			
Climb			
Lift*			

*If these activities are limited, please describe your limitation

Activity	Blocks	Miles	Minutes/Pounds
Walk			
Sit			
Lift			
Description of Limitation			

Describe the maximal physical activities you engage in:

Do you currently receive any of the following:	Yes	No
Government pension?		
Workers' Compensation Disability Payments?		
Social Security Disability Payments?		
Service-Connected Disability?		
Long-Term Disability?		
State Disability Insurance Fund (SDIF)?		
Has anyone else assisted you with this form?		

If yes, who?

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OCCUPATIONAL/ENVIRONMENTAL HISTORY

Please fill in the table, listing all jobs at which you have worked, including short-term, seasonal and part-time employment. Start with your present job and go back to your first. Use additional paper if necessary.

WORKPLACE/Employer's name and address	Dates Employed From	To	Full time or Part Time?	Type of industry	Were you ever off work for a health problem or injury? If yes, describe