WICHITA FAMILY MEDICINE SPECIALISTS, LLC

PATIENT MEDICAL QUESTIONNAIRE

Name_____ Date_____ Patient #_____

Age_____ Birthdate_____ Occupation_____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Main Complaints **For How Long**

a)_____ _____

b)_____ _____

c)_____ _____

d)_____ _____

Surgery or Hospitalization **Kind of Operation or Illness** **When**

a)_____ _____ _____

b)_____ _____ _____

c)_____ _____ _____

d)_____ _____ _____

Past Illnesses (Circle any illnesses) you have had and write date when

	When		When		When
Scarlet fever		Unconsciousness		Tuberculosis	
Pneumonia		High blood pressure		Diabetes	
Heart attach		Allergy		Chicken Pox	
Rheumatic fever		Kidney disease		Cancer	
Liver disease		Anemia		Asthma	

Family History	Age	If living - list any diseases	Age	If deceased list cause
Father				
Mother				
Brother [B] [ ]				
or Sister [S] [ ]				
[ ]				
[ ]				
[ ]				
Son [S] or [ ]				
Daughter [D] [ ]				

Have any of your blood relatives had the following diseases? (grandparents, blood-related aunts and uncles) (Circle if Yes)

Heart disease	Stroke	Kidney disease	Psychiatric disorder	High blood pressure
Cancer	Emphysema	Thyroid disease	Congenital disease	Alzheimer's
Diabetes	Osteoporosis	Allergy	Tuberculosis	

Social History

Tobacco: Yes____ No____ How much per day?_____

Alcohol: Yes____ No____ How much per day / week / month / year?_____

Routinely exercises: Yes____ No____ How often?_____

Number of servings of fruits and vegetables per day?_____

Caffeine consumption: Yes____ No____ Sexually active? Yes____ No____ Contraceptive method:_____

Do you always wear your seat belt? Yes____ No____ Do you wear a helmet? Yes____ No____

Medicines you are taking or have taken recently:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Allergy to medicine:

No_____ Yes (list)_____

See other side of form

Systems Review (Circle if Yes)

Metabolic System

Weight change _____
Warmer / Colder than others _____
Increased sweating _____
Goiter _____
Increased thirst _____
Increased urination _____
Skin, hair, nail changes _____

Head, Eyes, Ears, Nose, Throat

Headache _____
Hearing problem _____
Eye problem _____
Ear pain _____
Dizziness _____
Nasal drainage _____
Sore mouth / throat _____

Cardiovascular

Chest pain _____
Fast / irregular heartbeat _____
Ankle swelling _____
High blood pressure _____
Calf pain with walking _____

Respiratory

Short of breath _____
Wheezing _____
Raise phlegm _____
Cough up blood _____

Urinary

Blood in urine _____
Urinary frequency _____
Pain / burning with urination _____
Empty bladder at night _____
Bladder leakage _____

Female Patients -

Spot or menstruate: _____Yes _____ No
Every _____ days, for _____ days each period
Age of onset _____ Menopause _____
Last period _____ Last PAP smear _____
Breast changes _____
Calcium intake _____
Do you do self breast exam? _____ Yes _____ No
Number of pregnancies?_____

Male Patients -

Impotence _____
Changes in urinary stream_____
Testicular exam?_____ Scrotal lumps _____

Gastro-Intenstinal

Heartburn _____
Nausea / vomiting _____
Trouble swallowing _____
Abdominal pain _____
Blood in stools _____
Jaundice _____
Change in bowel habit _____
Constipation _____
Diarrhea _____
Belching / gas _____
Hemorrhoids _____

Musculoskeletal / Neuro / Psychiatric

Back pain _____
Joint pain _____
Stiff neck _____
Muscle weakness / paralysis _____
Tremor / shakes _____
Numbness / tingling _____
Convulsions _____
Fainting _____
Depression / anxiety _____
Stress _____
Sleep poorly _____

Blood / Lymphatic / Constitutional

Bleeding / Bruising _____
Anemia _____
Enlarged glands _____
Fever _____

Allergic / Immunologic

Hayfever _____
Asthma _____
Rashes / hives _____
Allergies _____

Vaccines:

Tetanus	No____	Yes (when) _____
Pneumonia	No____	Yes (when) _____
Hepatitis B	No____	Yes (when) _____
Flu	No____	Yes (when) _____
MMR	No____	Yes (when) _____

Please list other people in your household:

_____
_____
_____
_____

REMARKS:_____

_____
_____
_____

If you are interested in information in Living Wills and Durable Power of Attorney for Health Care Decisions, please ask your physician.

See other side of form