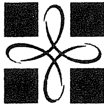

WICHITA FAMILY MEDICINE SPECIALISTS, LLC

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 attack		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** —

FMS-121 (07/01)

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 heatbeat ______
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-Intestinal

Heartburn ______
Nausea / vomiting ______
Trouble swallowing ______
Abdominal pain ______
Blood in stools ______
Black 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 on Living Wills and Durable Power of Attorney for Health Care Decisions, please ask your physician.

— **See other side of form** —