WESLEYCare Family Medicine Center

New Patient Medical Questionnaire

NAME _____ DATE _____

AGE_____ BIRTH DATE_____ SEX: MALE FEMALE

OCCUPATION_____ **Do you have a living will or DPOA?** Yes No

MARITAL STATUS:
Married Divorced
Widowed Single

ETHNIC BACKGROUND:
Black, not Hispanic Asian
Native American White
Hispanic Other _____

Do you have special needs?
Yes No
If yes, explain_____

Education Level: _____

LANGUAGE SPOKEN IN HOME: _____

SURGERY OR HOSPITALIZATION (List any surgeries or hospitalizations you have had)

	Year	Surgery or Hospitalization
a)		
b)		
c)		
d)		
e)		
f)		

PAST ILLNESSES (Circle any illnesses you have had)

Respiratory
Asthma
Emphysema/COPD
Pneumonia
Tuberculosis

Heart
Congestive Heart Failure
Heart Attack
High Blood Pressure
Palpitations

Abdomen
Kidney Disease
Liver Disease
Sexually Transmitted Infection

Nerves
Anxiety/Depression
Alzheimer's Disease
Seizures
Stroke

Hormone
Diabetes
High Cholesterol
Thyroid Disease

Blood
Anemia
HIV/AIDS
Sickle Cell Disease

Other
Alcohol/Drug Use
Allergy
Cancer

FAMILY HISTORY (Circle any illness your blood relatives have had, and list the relative)
(Grandparents, Parents, Brothers, Sisters, Children, Blood Related Aunts and Uncles)

Respiratory
Asthma
Emphysema/COPD
Pneumonia
Tuberculosis

Heart
Congestive Heart Failure
Heart Attack
High Blood Pressure
Palpitations

Abdomen
Kidney Disease
Liver Disease

Nerves
Anxiety/Depression
Alzheimer's Disease
Seizures
Stroke

Hormone
Diabetes
High Cholesterol
Thyroid Disease

Blood
Anemia
HIV/AIDS
Sickle Cell Disease

Other
Alcohol/Drug Use
Cancer

SOCIAL HISTORY

Tobacco: Yes No If yes, how much per day _____ Alcohol: Yes No If yes, how much per week _____
Recreational Drug Use: Yes No If yes, what? _____ How often? _____
Routine Exercise: Yes No If yes, how often _____ Do you always wear your seat belt? Yes No
Nutritional Assessment: # of meals per day _____ Number of servings of fruits and vegetables per day _____
Caffeine consumption per day _____ Contraceptive method _____
What do you do for your own enjoyment? (Hobbies, Leisure activities) _____
Do you feel safe at home? Yes No If no, please explain _____
Optional: What are your religious/spiritual beliefs? _____

MEDICINES YOU ARE TAKING OR HAVE TAKEN RECENTLY:

1 _____ **3** _____ **5** _____
2 _____ **4** _____ **6** _____

ALLERGY TO ANY MEDICINE No Yes If yes, please list _____

See other side ➡

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SYSTEMS REVIEW (Circle if YES) **Please circle any problems you are currently having and explain.**

METABOLIC /ENDOCRINE
Weight change _____
Warmer/Colder than others _____
Increased sweating _____
Neck swelling _____
Increased thirst _____
Increased urination _____
Skin, Hair, Nail Change _____

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 _____
Cough up drainage _____
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 _____
Number of pregnancies ____ Number of children _____
Breast changes _____
Calcium intake _____
Do you do breast self-exams? Yes No

REMARKS
_____
_____
_____

ALLERGIC/IMMUNOLOGIC
Allergies/Hay fever _____
Asthma _____
Rashes/Hives _____

GASTROINTESTINAL
Heartburn _____
Nausea/Vomiting _____
Trouble swallowing _____
Abdominal pain _____
Blood in stools _____
Black stools _____
Jaundice (Yellowing of Skin/Eyes) _____
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 _____
Suicide Attempts/Self-inflicted injury _____
Stress _____
Trouble Sleeping _____

BLOOD/LYMPHATIC/CONSTITUTIONAL
Bleeding/Bruising _____
Anemia _____
Enlarged glands _____
Fever _____

MALE PATIENTS
Impotence _____
Changes in urinary stream _____
Scrotal lumps _____
Last Testicular Exam _____

VACCINES
Do you have a copy of your vaccine record? Yes No

Please list the other people in your household:
_____
_____
_____

_____ _____
Physician/APRN Reviewed Signature **Date**