WESLEYCare Family Medicine Center

Patient Medical Questionnaire

NAME _____ DATE _____

AGE_____ BIRTH DATE_____ SEX: MALE FEMALE

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

MARITAL STATUS: **Do you have any special needs?**

Married Divorced Widowed Single Yes No If yes, explain_____

HOW DO YOU LEARN BEST? DEMONSTRATION LISTENING READING OTHER _____

SURGERIES OR HOSPITALIZATION OVER THE LAST YEAR ☐ NONE

Month/Year Surgery or Hospitalization

_____

_____

ILLNESSES OVER THE LAST YEAR ☐ NONE

Month/Year Illness

_____

_____

FAMILY HISTORY CHANGES IN THE LAST YEAR ☐ NO CHANGE

_____

_____

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 _____

REMARKS

_____

_____

_____

Please list the other people in your household:

_____

_____

_____

_____ _____

Physician/APRN Reviewed Signature **Date**