FAMILY CARE

ASSOCIATES, PC

1855 Halcyon Blvd.
Montgomery, AL 36117
334-530-6387

MEDICAL QUESTIONAIRRE

Name: _____ Date of Birth: _____/_____/_____

Race/Ethnicity: _____ Local Pharmacy: _____

Allergies: ☐ No Known Allergies (Please list allergies and what happens to you when you take the medication.)

_____ _____

_____ _____

_____ _____

Current Medications: ☐ None

_____ _____

_____ _____

_____ _____

Past Medical History: (please check all that apply)

☐ Allergies	☐ Colon Cancer	☐ Headaches: _____	☐ None
☐ Arrhythmia	☐ Congestive Heart Failure	☐ High Cholesterol	☐ Osteoarthritis
☐ Asthma	☐ COPD	☐ High Blood Pressure	☐ Osteoporosis
☐ Breast Cancer	☐ Coronary Artery Disease	☐ Hypothyroid	☐ Peptic Ulcer
☐ BPH (Enlarged prostate)	☐ Diabetes, Type I or II	☐ Iron Deficiency Anemia	☐ Prostate Cancer
☐ Carotid Artery Stenosis	(specify type) _____	☐ Lung Cancer	☐ Skin Cancer
☐ CVA (Stroke)	☐ Fracture repair _____	☐ MI (Heart Attack)	☐ Testicular Cancer
☐ Cholelithiasis (Gallstones)	☐ GERD (heartburn)	☐ Obesity	☐ Urinary Tract Infections
☐ _____	☐ _____	☐ _____	
☐ _____	☐ _____	☐ _____	☐ _____

PAST HOSPITALIZATIONS/SURGICAL HISTORY (please indicate date)

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

ADVANCED DIRECTIVES (Do you have any of the following documents?) (Please provide a copy.)

☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney ☐ DNR

OTHER MEDICAL PROVIDERS: (Please list all of your healthcare providers)

Specialists:

☐ _____ ☐ _____

☐ _____ ☐ _____

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FAMILY HISTORY: ☐ NONE/UNKNOWN

☐ AIDS: _____	☐ COPD: _____	☐ MI (Heart Attack): _____
☐ Alcoholism: _____	☐ Depression: _____	☐ Obesity: _____
☐ Alzheimer's: _____	☐ Diabetes I or II: _____	☐ Osteoarthritis: _____
☐ Anxiety: _____	☐ Chemical dependency: _____	☐ Osteoporosis: _____
☐ ADD/ADHD: _____	☐ Hepatitis C: _____	☐ Ovarian Cancer: _____
☐ Asthma: _____	☐ High Blood Pressure: _____	☐ Prostate Cancer: _____
☐ BPH (Enlarged prostate): _____	☐ High Cholesterol: _____	☐ Rheumatoid Arthritis: _____
☐ Breast Cancer: _____	☐ HIV: _____	☐ Seizure Disorder: _____
☐ Stroke: _____	☐ Hypothyroid: _____	☐ Other: _____
☐ Gall Stones: _____	☐ Kidney Stones: _____	☐ Other: _____
☐ Colon Cancer: _____	☐ Lung Cancer: _____	☐ Other: _____

SOCIAL HISTORY:

Occupation: _____ Place of employment: _____

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled

☐ Married ☐ Single ☐ Divorced ☐ Widow Number of Children: _____

Hobbies/Activities: _____

Exercise: (Type) _____ How Often: _____

Alcohol/Supplements/Tobacco:

Do you use Tobacco? ☐ Never Smoked

	Past	Quit Date	Current	How Much	How Long
Cigarettes	☐	_____	☐	_____	_____
Cigars	☐	_____	☐	_____	_____
Smokeless	☐	_____	☐	_____	_____

Do you use Alcohol?	☐ Never Used	How much	How Often
	☐ Beer	_____	_____
	☐ Wine	_____	_____
	☐ Liquor	_____	_____
Caffeine intake:	☐ None		
	☐ Coffee	_____	_____
	☐ Tea	_____	_____
	☐ Soda	_____	_____
Substance Abuse:	☐ Never Used	Type: _____	How often: _____

Mental Health: ☐ None ☐ Yes Details: _____

Communicable disease: ☐ None ☐ Yes Details: _____

Comments: _____

_____ _____

Signature: Patient/Guardian Date

_____ _____

Print Name Relationship to patient