St. Charles Family Medical Center, S.C.
110 S. 17th Street * St. Charles, IL 60174 * (630) 377-2800 * (630) 377-6774

PATIENT QUESTIONNAIRE

DATE: _____ ADULT (18 years or older)

NAME: _____ Use additional sheets if

BIRTHDATE: _____ necessary for any questions

I. I am allergic to the following (include medicines, foods, pollens, etc., and type of reaction):

_____

_____

II. I am taking the following medicines regularly (include birth control pills, Aspirin, and over-the counter medications):

_____

_____

III. I have had the following operations:

OPERATION	DATE	HOSPITAL	SURGEON

_____

_____

IV I have been in the hospital for other problems:

PROBLEM	DATE

_____

_____

V I have seen other doctors regularly _____Yes _____No

List doctors and specialties: _____

_____

VI. My last tetanus shot was (date) : _____

I smoke cigarettes _____Yes _____No How many packs per day? _____

I drink alcohol _____Yes _____No How much at one time? _____ How often?_____

I use drugs _____Yes _____No How often? _____

Exercise: Type _____ How often?_____

Any recent weight change? _____Yes _____No Loss _____ Gain_____

Do you have an advance directive? (Someone in charge of making your medical decisions in the event you are unable).

_____Yes _____No If so, list the name of the person responsible:_____

ADULT NEW PATIENT QUESTIONNAIRE

VI. My current and past occupations are:

OCCUPATIONS DATES SPECIAL HAZARDS, IF ANY

(Present) _____

(Past) _____

VII For the following, check the first column if you have the listed condition and the second column if it runs in your family. If you check the second column, please indicate the relationship.

	YOU	**FAMILY MEMBER**	**RELATIONSHIP**
Diabetes (sugar disease)	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Heart Attack	_____	_____	_____
Cancer	_____	_____	_____
Other:_____	_____	_____	_____
Other: _____	_____	_____	_____

VIII Please list below the name, age, and relationship for all people who live with you. Please mark the last space for any person who has seen a doctor here.

NAME AGE RELATIONSHIP TO YOU DOCTOR

_____

_____

_____

IX. Other information we should know that we haven't asked:

_____

_____

X **For Women Only:**

Age periods began: _____ Number of pregnancies: _____

Frequency of periods: _____ Number of live births: _____

Number of days of flow: _____ Number of miscarriages/abortions: _____

Birth control method: _____ Date of last pap smear: _____

Do you see another doctor for gynecological checkups? _____Yes _____No

Are you immune to Rubella (German Measles)? _____Yes _____No