GILL FAMILY MEDICINE
PATIENT MEDICAL QUESTIONNAIRE

NAME _____ DATE _____

DATE OF BIRTH _____ RACE_____ GENDER_____ PREFERRED LANGUAGE _____

ETHNICITY (Circle One): Latino or Hispanic, Non-Latino or Non-Hispanic, Patient Refused

Please indicate whether you have ever had any of the following.
Circle all that apply.

PREVIOUS PROBLEMS:

Acid Reflux
Allergies
Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Back Pain or Injury
Blood Clots
Blood in Urine
Cancer
Colon Polyps
Color Blindness
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes
Diverticulosis
Eating Disorder
Emphysema
Excessive Anger or Violence
Eye Disease
Glasses or Contacts
Glaucoma
Gout
Hearing Loss
Heart Attack
Heart Disease
Heart Valve Problems
Hepatitis
High Blood Pressure
High Cholesterol
Kidney Disease
Kidney Stones
Liver Disease

PREVIOUS PROBLEMS CON'T:

Migraine Headaches
Mitral Valve Prolapse
Mood Swings
Osteoporosis
Pneumonia
Seizure Disorder
Stomach or Colon Cancer
Stroke
Suicide Attempts
Thyroid Problems
Tuberculosis
Unusual Bleeding
Venereal Disease

WOMEN'S HEALTH:

Abnormal Pap Smear
Endometriosis
Fibrocystic Disease
Lumps in Breast

PAST SURGICAL HISTORY:

Appendectomy
Back Surgery
Brain or Head Surgery
Colonoscopy
Chest or Lung Surgery
Gallbladder Surgery
Heart Catheterization
Hysterectomy
Joint Surgery
Kidney Surgery
Open Heart Surgery
Pace Maker
Tonsillectomy
Tubal
Vasectomy

Please indicate if any family members have had any of the following:
(Circle all that apply and indicate which family member.)

PROBLEM	FAMILY MEMBER	PROBLEM	FAMILY MEMBER
Alcoholism		Diabetes	
Alzheimer's Disease		Hyperlipidemia	
Blood Disease		High Blood Pressure	
Coronary Artery Disease		Mental Illness	
Cancer		Osteoporosis	
Depression		Stroke	

MARTIAL STATUS (CIRCLE)
Single Married Divorced

CHILDREN (GIVE NUMBER)
Daughters___ Sons___

TOBACCO USE **TYPE** **FREQUENCY** **TRIED TO QUIT**
Yes No Yes No

ALCOHOL USE **TYPE** **FREQUENCY** **TRIED TO QUIT**
Yes No Yes No

Do you have a living will? Yes No

_____ _____
Patient's Signature Date

_____ _____
Signature of Legal Guardian or POA Date