LAKEPOINT FAMILY PHYSICIANS

James F. Hesse, M.D.
Diana R. Crook, M.D.
Kurt M. Hesse, M.D.
Jennifer J. Halabi, M.D.
Lynnette S. Jacobsen, M.D.
Nicole Z. Arensdorf, M.D.

8020 E. Central Ave. Suite 200 ~ Wichita, KS 67206 ~ (316) 636-2662

Patient Medical Questionnaire

Please fill out this information sheet (both sides) to help your doctor.

Name:_____ Today's Date:_____ Your doctor:_____

Age:_____ Birthdate:_____ Occupation:_____

Sex: ___-Male ___-Female Single:___ Married:___ Separated:___ Divorced:___ Widowed:___

MAIN COMPLAINTS: For how long?

a)_____ _____

b)_____ _____

c)_____ _____

SURGERY or HOSPITALIZATION: Kind of operation or illness? When?

a)_____ _____

b)_____ _____

c)_____ _____

PAST ILLNESSES: Circle any illnesses you have had and write down when:

	When?		When?		When?
Scarlet fever	_____	Unconsciousness	_____	Tuberculosis	_____
Pneumonia	_____	High blood pressure	_____	Diabetes	_____
Heart attack	_____	Rheumatic fever	_____	Chicken Pox	_____
Allery	_____	Kidney disease	_____	Cancer	_____
Anemia	_____	Liver disease	_____	Asthma	_____

FAMILY HISTORY:	Age	If living--list any disease	Age	If deceased, list cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(B) ( )	_____	_____	_____	_____
Sister(sis)( )	_____	_____	_____	_____
( )	_____	_____	_____	_____
( )	_____	_____	_____	_____
Son [S] [ ]	_____	_____	_____	_____
Daughter[D][ ]	_____	_____	_____	_____
[ ]	_____	_____	_____	_____

Have any of your blood relatives (including grandparents, blood-related aunts or uncles) had the following diseases? Circle if Yes

Heart disease	Stroke	Kidney disease	Psychiatric disorder	Tuberculosis
Cancer	Emphysema	Thyroid disease	Congenital disease	Alzheimer's
Diabetes	Allery	Osteoporosis	High blood pressure	

SOCIAL HISTORY: Tobacco: Yes[ ] No[ ] How much per day?_____

Alcohol: Yes[ ] No[ ] How much per day____/week____/month____/year____

Substance Abuse/Addiction :_____

Caffeine consumption: Yes[ ] No[ ]. Regular Exercise: Yes[ ] How often?_____

Servings [_____] fruits & vegetables per day. Do you always wear your seat belt? Yes[ ] No[ ]

Sexually active? Yes[ ] No[ ] Method of family planning?_____

--See other side of form--

Please list the MEDICATIONS you are currently taking:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

ALLERGIES TO MEDICATIONS? [ ] NO. [ ] YES. If yes, list below and describe reaction.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Systems Review (Check if Yes)

METABOLIC

Weight Change [ ]
Warmer/colder than others [ ]
Increased sweating [ ]
Goiter [ ]
Increased thirst [ ]
Increased urination [ ]
Skin, hair, nail change [ ]

RESPIRATORY

Short of breath [ ]
Wheezing [ ]
Raise phlegm [ ]
Cough up blood [ ]

CARDIOVASCULAR

Chest pain [ ]
Fast heartbeat [ ]
Irregular heartbeat [ ]
Ankle swelling [ ]
High blood pressure [ ]
Calf pain walking [ ]

BLOOD/LYMPHATIC & CONSTITUTIONAL

Bleeding/Bruising [ ]
Anemia [ ]
Enlarged glands [ ]
Fever [ ]

GASTROINTESTINAL

Heartburn [ ]
Nausea/Vomiting [ ]
Trouble swallowing [ ]
Abdominal pain [ ]
Blood in stools [ ]
Black stools [ ]
Jaundice [ ]
Change in bowel habits [ ]
Constipation [ ]
Diarrhea [ ]
Belching/Gas [ ]
Hemorrhoids [ ]

HEAD/EYES/EARS/NOSE/THROAT

Headache [ ]
Hearing problem [ ]
Eye problem [ ]
Ear pain [ ]
Dizziness [ ]
Nasal drainage [ ]
Sore mouth or throat [ ]

URINARY

Blood in urine [ ]
Urinary frequency [ ]
Pain with urinating [ ]
Burning urinating [ ]
Empty bladder at nighttime [ ]
Bladder leakage [ ]
Urgency [ ]

MUSCULOSKELETAL/ NEURO/PSYCHIATRIC

Back pain [ ]
Joint pain [ ]
Stiff neck [ ]
Muscle weakness [ ]
Paralysis [ ]
Tremor/Shakes [ ]
Numbness/Tingling [ ]
Convulsions [ ]
Fainting [ ]
Depression/Anxiety [ ]
Stress [ ]
Sleeping poorly [ ]

ALLERGIC/IMMUNOLOGIC

Hay fever [ ]
Asthma [ ]
Rashes/Hives [ ]
Allergies [ ]

NON-MEDICATION ALLERGIES?
If yes, please list:

_____
_____
_____
_____

FEMALE PATIENTS--

Spot or menstruate: _____Yes _____No
(Every _____ days, for _____ days each period.)
Age of onset_____ Menopause_____
Last period:_____ Last Pap smear:_____
Breast changes:_____
Number of pregnancies, deliveries,
complications, children & ages: _____
_____
_____
Calcium intake:_____
Do you do self breast exam? _____Yes _____No

VACCINES:

Tetanus-----No_____ Yes(When?)_____
Pneumonia---No_____ Yes(When?)_____
Hepatitis B---No_____ Yes(When?)_____
Flu----------No_____ Yes(When?)_____
MMR----------No_____ Yes(When?)_____

MALE PATIENTS--

Impotence:_____
Changes in urinary stream_____
Testicular exam?_____
Scrotal lumps?_____

If you are interested in information on a Living Will and Durable Power of Attorney, please ask your physician.