CAROLINA FAMILY CARE

Internal Medicine, 30 Bee Street

Patient History and Medical Information

MR/ACCT #: ____________________ DATE: ____________________

PATIENT NAME: ____________________ DATE OF BIRTH: ____________ AGE: ______

MAIN REASON FOR SEEING THE DOCTOR TODAY:

____

____

____

Are there any other problems you would like to discuss during your visit today?

____

____

LIST ANY MEDICATION YOU ARE NOW TAKING OR HAVE TAKEN IN THE LAST 3 MONTHS:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PAST MEDICAL HISTORY (Please √ any illness that you have had as a child or adult)

- ☐ Mumps
- ☐ Measles
- ☐ Mononucleosis
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Gallbladder Attacks
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Diabetes Mellitus
- ☐ High Blood Pressure
- ☐ Tumors / Cancer
- ☐ Convulsions
- ☐ Seizures
- ☐ Rheumatism
- ☐ Arthritis
- ☐ Ulcers
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Broken Bones
- ☐ Other: ____________

LIST ALL HOSPITALIZATIONS AND SURGERIES

Reason for Hospitalization	Date	Hospital Name City, State	Physician

Have you been immunized against any of the following? If so, when?

Tetanus_______________ Pneumonia_______________ Hepatitis_______________ Influenza_______________

When was your last TB skin test? (PPD)_______________ Was it Positive or Negative

Do you have any risk factors for HIV (AIDS)? (Blood transfusions, multiple partners, IV drug use, etc.)

____

Do you have any drug allergies? ☐ YES ☐ NO If yes, please list type of reaction.

Do you have any food allergies? ☐ YES ☐ NO If yes, please list type of reaction.

____

____

HABITS

Do you smoke? ☐ YES ☐ NO Former smoker? Quit date_____________ # Packs per day____ # of years____

Do you drink alcohol? ☐ YES ☐ NO ☐ Occasionally ☐ Frequently How many drinks per day?_____

Do you drink coffee/tea or other caffeinated beverages? ☐ YES ☐ NO Cups per day?_____

Do you exercise regularly? ☐ YES ☐ NO How many times per week?_____ Type______________________

WEIGHT

Weight last year________ Highest Weight________ Lowest Weight_____

FAMILY HISTORY

	SEX	AGE	LIVING OR DECEASED	CAUSE OF DEATH	MEDICAL HISTORY
Father	M				
Mother	F				
Brothers or Sisters					
Children					

Do you have any blood relatives who have had the following illnesses? (Please √ those that apply)

ILLNESS	WHO	ILLNESS	WHO
☐ Cancer		☐ Heart Disease	
☐ Seizures		☐ Nerves / Depression	
☐ Osteoporosis		☐ Diabetes	
☐ Thyroid Problems		☐ Migraine Headaches	

Any other illness?______________________________

SOCIAL HISTORY

Describe your general state of health: (Circle one) GOOD FAIR POOR

Birthplace________________ Were you raised there?________ If not, where?____________________

Education (Circle the highest grade completed)

Elementary 1 2 3 4 5 6 7 8 High School 9 10 11 12 Diploma received? _____

College 1 2 3 4 Degree?____________________ Post Graduate____________________

Marital Status________________ Spouse's name and occupation____________________________

Your occupation (Please describe nature of work, number of years employed in this occupation, occupational hazards that may exist.)

____

____

REVIEW OF SYSTEMS (Please answer all by circling yes or no and completing the blank when indicated)

SKIN			PLEASE EXPLAIN
Have you ever seen a dermatologist?	YES	NO	Why?
Have you ever had any changes in color or texture of skin? Moles?	YES	NO	
Have you had skin cancer?	YES	NO	Type?
Have you ever had hives or a rash?	YES	NO	
HEMATOLOGICAL			
Have you ever been treated for severe anemia (low blood)?	YES	NO	
Do you have any enlarged lymph glands (kernels)?	YES	NO	
Have you ever had a blood transfusion?	YES	NO	When?
HEENT			
Is your eyesight getting worse?	YES	NO	Last eye exam?
Do you currently wear glasses or contact lenses?	YES	NO	
Do you have glaucoma? Cataracts?	YES	NO	
Are you hard of hearing?	YES	NO	Hearing aid?
Have you ever had severe or recurrent ear infections?	YES	NO	
Do you have frequent episodes of dizziness or light-headedness?	YES	NO	
Did you ever have mastoiditis or mastoid surgery?	YES	NO	
Do you hear constant noises in your ears?	YES	NO	

HEENT (cont'd)			**PLEASE EXPLAIN**
Do you have frequent stuffed up or runny nose?	YES	NO	
Have you at times had nosebleeds?	YES	NO	
Do you have false teeth?	YES	NO	
Do you have bleeding gums?	YES	NO	
Have you had a recent change in voice?	YES	NO	
CARDIOVASCULAR / RESPIRATORY			
Are you troubled by chronic coughing?	YES	NO	
Do you bring up phlegm everyday? Color__________ Amount_________	YES	NO	
Have you ever coughed up blood?	YES	NO	
Do you sometimes have severe soaking sweats at night?	YES	NO	
Have you ever had TB (Tuberculosis)?	YES	NO	
Has a doctor ever said that your blood pressure was too high?	YES	NO	
Have you ever taken medication for high blood pressure?	YES	NO	
Do you get tightness, pressure, squeezing, or burning in the chest?	YES	NO	
Are you bothered by thumping of the heart or palpitations?	YES	NO	
Do you have difficulty breathing?	YES	NO	
Do you have a heart murmur or mitral valve prolapse? Do you take antibiotics prior to dental work?	YES YES	NO NO	
Do you have an enlarged heart?	YES	NO	
Do you get severe pains in your legs while walking?	YES	NO	
Do you ever have problems with swelling feet or ankles?	YES	NO	
GI/DIET			
Is your appetite poor?	YES	NO	
Do you often suffer from an upset stomach?	YES	NO	
Is it difficult or painful for you to swallow?	YES	NO	
Do you have heartburn or take antacids regularly?	YES	NO	
Have you ever vomited blood?	YES	NO	
Have you ever had bloody or black stools?	YES	NO	
Do you suffer from frequent loose or painful bowel movement?	YES	NO	
Do you frequently use laxatives for constipations?	YES	NO	
Have you had a recent change in your bowel habits?	YES	NO	
Have you ever had piles (rectal hemorrhoids)?	YES	NO	
Have you ever had jaundice (yellow eyes and skin)?	YES	NO	
Have you ever had a flexible sigmoidoscopy or colonoscopy?	YES	NO	Most recent exam date:
GU			
Were you ever treated for a venereal disease?	YES	NO	
Have many times you get up during the night to urinate?	YES	NO	# of times:
Do you sometimes lose control of your bladder?	YES	NO	
Has your urine been brown, black, or bloody?	YES	NO	
Have you had kidney stones or kidney colic?	YES	NO	
Have you had any problem having sexual relations?	YES	NO	

MUSCULOSKELETAL			PLEASE EXPLAIN
Are your joints ever painfully swollen, stiff, or hot?	YES	NO	
Were you ever told you had arthritis?	YES	NO	
ENDOCRINE			
Do you have diabetes?	YES	NO	
Did a doctor ever say you had a goiter or thyroid problem?	YES	NO	
MALE			
Have you ever had anything seriously wrong with your genitals?	YES	NO	
Has a doctor ever said you had a hernia or prostate trouble?	YES	NO	
Have you had a vasectomy? Do you have difficulty with erections?	YES YES	NO NO	
FEMALE			
Last PAP smear? Date_______________________			Dr. Name
How old were you when you started to menstruate?_________			
Do you have a regular OB/GYN physician?	YES	NO	Dr. Name
When was your last menstrual cycle? Date_______________________			
Have you ever had an abnormal pap smear?	YES	NO	When?
Do you use contraceptives (birth control)?	YES	NO	What?
If reached menopause, date of menopause_________________			
Number of pregnancies_____ Number of children_____			
Number of miscarriages_____			
Do you have hot flashes or symptoms of menopause?	YES	NO	
Have you taken female hormones?	YES	NO	Drug Name
Have you had any vaginal bleeding since the menopause?	YES	NO	
Have you ever had lumps or tumors in the breast?	YES	NO	Any biopsies?
Have you ever had pain or discharge from the nipples?	YES	NO	
Have you had a mammogram? Date of last mammogram______________	YES	NO	
CONSTITUTIONAL			
Have you ever been knocked unconscious?	YES	NO	
Have you ever had a fit or convulsion (Epilepsy)?	YES	NO	
Do you often get spells of complete exhaustion or fatigue?	YES	NO	
Do you have frequent crying spells?	YES	NO	
Do you frequently wake of tired and exhausted in the morning?	YES	NO	
Do you have difficulty sleeping at night?	YES	NO	
How may hours at night do you sleep on average?	YES	NO	
Do you get depressed?	YES	NO	
Have you ever seriously considered suicide?	YES	NO	
Do you have a history of insomnia or sleep apnea?	YES	NO	
Have you ever sought or desired psychiatric help?	YES	NO	

THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS LENGTHY QUESTIONNAIRE TO ASSIST US WITH PROVIDING YOU WITH THE BEST HEALTHCARE POSSIBLE.