

Carolina Medical Associates

PLEASE PRINT CLEARLY.....

Name _____ Referred by: _____

Email Address: _____

Occupation _____ Prior jobs _____

Date of Birth _____ M ___ F ___ Reason for Referral _____

Main Complaints & History of Present Illness _____

Past Medical History

- Surgical 1. _____ When _____
- 2. _____ When _____
- 3. _____ When _____
- 4. _____ When _____
- 5. _____ When _____

Past Medical Problems

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

Family & Social History

Marital Status M _____ S _____ Divorced _____ Widowed _____

List Family Members & Health

- Sons....How Many?? _____
- Name _____ Age _____ Health _____
- Name _____ Age _____ Health _____
- Name _____ Age _____ Health _____

Daughters...How Many?? _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____

Father...Name _____ Age _____ Health _____

Mother..Name _____ Age _____ Health _____

Brothers...How Many?? _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____

Sisters.....How Many?? _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____
Name _____ Age _____ Health _____

Any Family History of ??? Hypertension _____ Who _____
Diabetes _____ Who _____
Heart Disease _____ Who _____
Cancer _____ Who _____
Mental Illness _____ Who _____
Alcoholism _____ Who _____

List Any Other Problems _____

Social History.....
Do You Smoke? _____ How much per day? _____ How Long? _____
Drink Alcohol? _____ How much? _____ What Kind? _____

Allergies.....To Medicines_____

Any Other Allergies_____

List Present Medications You Take.._____

List Herbal Medications/Vitamins You Take.._____

Do You Have a Drug Problem? Explain_____

Do You Want Help for Drug Problems?_____

Review of systems.....**CHECK IF ANY**.....

Head: Headaches_____ Dizziness_____

Eyes: Blurred Vision Left____Right____ Vision Loss Left____Right____
Double Vision Left____Right____ Cataracts Left____Right____

Ears: Hearing Loss Left____Right____ Hearing Aid Left____Right____
Ringing Ears Left____Right____ History of Ear Infections?_____

Nose: Nose Bleed Left____Right____ Sinus Problems_____
Injuries_____ When_____

Chest: Unusual cough_____ Coughing Blood_____
Shortness of Breath_____ Chest Pain_____ Chest Tightness_____
Last Chest Xray When?_____ Where?_____

Heart: Heart Murmur_____ Heart Palpitations_____
Squeezing pain/Pressure on chest_____
Last EKG When?_____ Where?_____
Last Stress Test When?_____ Where?_____

GI: Difficulty Swallowing_____ Heartburn_____ Ulcer_____
Bleeding Ulcer_____ Nausea_____ Vomiting_____
Diarrhea_____ Constipation_____ Blood in Stool_____
Hemorrhoids_____ Last Flex Sigmoidoscopy When?_____
Where Flex Sig was done_____ Weight loss_____

Genito-Urinary: Blood in Urine_____ Burning with Urination_____ Frequency_____
Urination at night_____ Leakage_____ History of bladder infection_____
Kidney Stones_____ Sexually Transmitted Diseases_____

CHECK IF ANY.....

Musculoskeletal: Joint Pain_____ Describe _____
Swelling Joints_____ Describe _____
Back Pains_____ Describe _____
Abnormal Sensation_____ Describe _____

Skin: Any Rash_____ Acne_____ Easy Bruising_____

For Females: Age Period started_____ Regular?_____ Days of Flow _____
Last Pap Smear When?_____ Where? _____
Use of Contraceptives_____ Result _____
Vaginal discharge_____ Number of births_____ C-Sections _____
Miscarriages_____ DNC _____ Abortions _____

Breasts: Any pain_____ Any lumps_____ Nipple Discharge _____
Last Mammogram When?_____ Where? _____
Night sweats_____ Hot flashes _____

For Males: Penile discharge_____ Prostate problems_____ Erection Problems _____
Last Rectal exam When? _____
Do You Want Doctor to Discuss any Problems Further? _____

Vaccines: Last TB Test When _____ Tetanus . When _____
Hepatitis A When _____ Hepatitis B . When _____
Flu Vaccine When _____ Pneumonia Vaccine . When _____

PLEASE BRING A RECORD OF YOUR VACCINATIONS TO THE OFFICE....

Do you have a LIVING WILL? _____

Do you have a HEALTHCARE POWER OF ATTORNEY? _____
(Name of Power of Attorney)