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_____
Hemorroids_____Last Flex Sigmoidoscopy When?_____
Where Flex Sig was done_____Weight loss_____

Genito-Urinary: Blood in Urine_____Burning with Urination_____Frequentcy_____
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 Disharge_____
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)