CAROLINA MEDICAL ASSOCIATES

PLEASE PRINT CLEARLY.....

Name_____ DOB:_____

Past Medical Problems

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Surgical History

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Family History

Marital Status M_____ S_____ Divorced_____ Widowed_____

How many sons?_____

How many daughters?_____

Any Family History of:

Hypertension_____

Diabetes_____

Heart Disease_____

Cancer_____

Mental Illness_____

When was your last:

Annual Physical Exam_____

Pap Smear_____

Chest Xray_____

EKG_____

Mammogram_____

Colonoscopy_____