CAROLINA MEDICAL CONSULTANTS, PA NAME: ____________________
HEALTH HISTORY QUESTIONNAIRE DOB: ___/____/__________

Your answers on this form will help your health care provider better understand your medical concerns and conditions

Main reason for today's visit:

____

Other concerns:

____

How did you hear about us?

____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY: ____________________ Address and/or phone #: ________________________

Mailorder pharmacy if applicable: ____

MEDICATIONS

Please list all the medications you are taking. Include **prescribed drugs** and **over-the-counter drugs**, such as **vitamins, aspirin, herbals,** and **inhalers**.

DRUG NAME	STRENGTH	FREQUENCY TAKEN	FOR WHAT REASON?
1.			
2.			
3.			
4.			
5.			
6 .			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

IMMUNIZATION HISTORY

Immunizations and most recent date:

Tdap (Tetanus and pertussis) Date:__________

Hepatitis B Date:_________________

Pneumonia Date:_________________

Hepatitis A Date:_________________

Chickenpox Date: _______________

Flu Shot Date:________________

MMR (Measles, Mumps, Rubella) Date:_______

Gardasil/HPV Date:_________________

Meningococcus Date :_______________

Zostavax (Shingles) Date:__________________

Tetanus Date:_________________

(WOMEN ONLY) OBSTETRIC & GYN HISTORY

Last Pap Smear date: _________ Abnormal Y/N

Last Mammogram date: ________ Abnormal Y/N

Age of first menstrual period: ________

Date of last menstrual period or age of menopause: ________

Number of pregnancies? _____ births? ______

miscarriages? ______ abortions? _______

C-sections? _________

Are you experiencing any of the following?

❑bleeding between periods ❑painful intercourse

❑Heavy periods ❑Extreme menstrual pain

❑Vaginal itching, burning, or discharge

❑Breast lump ❑Nipple discharge ❑hot flashes

PAST MEDICAL HISTORY

Please check all that apply:

❑Abnormal Pap Smear
❑Atrial Fibrillation
❑Anxiety Disorder
❑Arthritis
❑Asthma
❑Bleeding Disorder
❑Blood Clots (or DVT)
❑Cancer: ____________
❑Coronary Artery Disease
❑Diabetes
❑Dialysis
❑Depression
❑Diverticulosis
❑Eye disorder:____________
❑Fibromyalgia
❑Gout
❑Heart Attack
❑Heart Murmur
❑Hiatal Hernia or Reflux Disease
❑High Blood Pressure
❑High Cholesterol
❑HIV or AIDS
❑Kidney Stones
❑Kidney disease
❑Leg/Foot Ulcers
❑Liver Disease/Fatty Liver
❑Lupus
❑Osteoporosis
❑Pacemaker
❑Pulmonary Embolism
❑Reflux or Ulcers
❑Sleep Apnea/CPAP
❑Stroke
❑Tuberculosis
❑Thyroid problem
❑Other: ____
❑Other: ____
❑Other: ____
❑Other: ____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL/ SURGEON
1.__________________________	__________________________	__________________	____________
2.__________________________	__________________________	__________________	____________
3.__________________________	__________________________	__________________	____________
4.__________________________	__________________________	__________________	____________
5.__________________________	__________________________	__________________	____________

PROCEDURAL/EXAM HISTORY:

If applicable, state the **most recent date** and **where** you have had any of the following.

	DATE	DOCTOR/FACILITY
Colonoscopy:	___________________	______________________________
Heart test (Stress test, ECHO, EKG):	___________________	______________________________
Bloodwork/Labs:	___________________	______________________________
Physical/Complete Medical Exam:	___________________	______________________________
Bone Density Scan/DEXA:	___________________	______________________________
Eye Exam:	___________________	______________________________

FAMILY HEALTH HISTORY: ****INCLUDE PARENTS, GRANDPARENTS, SIBLINGS, AND CHILDREN*****

DIAGNOSIS	WHO HAD IN FAMILY	AGE OF ONSET
Alcoholism	_____________________	_______________
Anxiety/Depression	_____________________	_______________
Abnormal cholesterol levels	_____________________	_______________
Cancer	_____________________	_______________
Dementia/Alzheimers	_____________________	_______________
Diabetes	_____________________	_______________
Eye disease	_____________________	_______________
Genetic disorders	_____________________	_______________
Heart disease	_____________________	_______________
High blood pressure	_____________________	_______________
Osteoporosis	_____________________	_______________
Stroke	_____________________	_______________

If any of the above family members you listed are deceased, please give age at death and reason:

SOCIAL HISTORY

Occupation: ___________________

Education

- ☐ Less than 9th grade
- ☐ High school
- ☐ 2 year college
- ☐ 4 year college
- ☐ Post graduate

Marital Status

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Domestic partner

Exercise Level

- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Type: ___________________

Caffeine (include Tea)

☐None

-or-

# of cups/cans per day? ______

Drugs

Do you currently use recreational or street drugs?

☐Yes ☐No

If yes, list: __________________

Alcohol

Do you drink alcohol?

☐Yes ☐No

If so, how often?

☐Occasionally

☐< 3 times a week

☐> 3 times a week

How many drinks per week? __

Tobacco Use:

- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Chewing Tobacco

Type: _______________

- ☐ Secondhand smoke exposure
- ☐ Current everyday smoker

Amt: ________________

- ☐ Current some day smoker

Amt: ________________

REVIEW OF SYSTEMS

Have you ***recently*** had reoccurring symptoms of any of the following:

Allergic/Immunologic
- ▢Frequent Sneezing
- ▢Hives
- ▢Itching
- ▢Runny Nose
- ▢Sinus Pressure

Cardiovascular
- ▢Arm Pain on Exertion
- ▢Chest Heaviness /Pressure on Exertion
- ▢Chest Pain on Exertion
- ▢Irregular heart beats (palpitations)
- ▢Known heart murmur
- ▢Light-headed on standing
- ▢Shortness of breath when lying down
- ▢Shortness of breath when walking
- ▢Swelling (edema)

Eyes
- ▢Dry Eyes
- ▢Irritation
- ▢Vision Change

Ears/Nose/Mouth/ Throat
- ▢Bleeding Gums
- ▢Dizziness
- ▢Difficulty Hearing
- ▢Dry Mouth
- ▢Ear Pain
- ▢Frequent Nosebleeds
- ▢Frequent Infections
- ▢Hoarseness
- ▢Mouth Breathing
- ▢Mouth Ulcers
- ▢Nose/Sinus Problems
- ▢Ringing in Ears

Endocrine
- ▢Fatigue
- ▢Increased Thirst / Hunger / Urination

Gastrointestinal
- ▢Abdominal Pain
- ▢Black or Tarry Stool
- ▢Blood in Stool
- ▢Change in Appetite
- ▢Frequent Indigestion
- ▢Hemorrhoids
- ▢Trouble Swallowing
- ▢Vomiting
- ▢Vomiting Blood

Constitutional
- ▢Exercise Intolerance
- ▢Fatigue
- ▢Fever
- ▢Weight Gain (____lbs)

Genitourinary
- ▢Blood in Urine
- ▢Difficulty Urinating
- ▢Incomplete Emptying
- ▢Increased Urinary Frequency
- ▢Urinary Loss of Control
- ▢Erectile Dsyfunction
- ❑Do you use condoms? Y / N
- ❑Other form of birth control? _____________
- ❑Interested in being screened for STD's? Y / N

Hematologic/Lymphatic
- ▢Easy Bruising /Bleeding
- ▢Swollen Glands

Integumentary (Skin)
- ▢Changes in Moles
- ▢Dry Skin
- ▢Eczema
- ▢Growth/Lesions
- ▢Itching
- ▢Jaundice (Yellow Skin/Eyes)
- ▢Rash

Musculoskeletal
- ▢Back Pain
- ▢Joint Pain
- ▢Muscle Aches
- ▢Muscle Weakness

Neurological
- ▢Fainting
- ▢Dizziness
- ▢Headaches
- ▢Memory Loss
- ▢Migraines
- ▢Numbness
- ▢Restless Legs
- ▢Seizures
- ▢Weakness

Respiratory
- ▢Cough
- ▢Coughing Up Blood
- ▢Shortness of Breath
- ▢Sleep Apnea
- ▢Snoring
- ▢Wheezing

Psychiatric
- ▢Alcohol Overuse
- ▢Anxiety/Stress
- ▢Depression
- ▢Do Not Feel Safe in Relationship(s)
- ▢Mania
- ▢Sleep Problems

Please list all other doctors and/or medical specialists you are currently seeing (Include GYN, eye doctor, and dentist):

____
____
____
____

Please add any other information about your health that you would like your provider to know here:

____
____
____
____

____ ____________________

Patient **OR** Parent, Guardian, or Caregiver Signature Date