Carolinas HealthCare System

Mecklenburg Medical Group

Medical Record Number: _____

Name: _____

Date: _____

PERSONAL HISTORY REVIEW

Reason for visit: _____ Referred by: _____

Physicians seen in last 5 years: _____

PAST MEDICAL HISTORY

Medication allergies and reactions: _____

Surgical operations and dates: _____

MEDICATIONS (prescribed & over the counter): _____

PERSONAL AND FAMILY MEDICAL HISTORY

	Self	Mother	Father	Sister	Brother	Child	Other
High Blood Pressure							
Heart Attack (age)							
High Cholesterol							
Diabetes							
Stroke							
Cancer (type)							
Thyroid Trouble							
Asthma							
Depression							
Anxiety							
Substance Abuse							
Heart Failure							
COPD							
Colon Polyps							
Osteoporosis							
Stomach Ulcers							

Any other medical conditions? _____

Number of Daughters _____ Number of Sons _____

Mother living? ☐ Yes ☐ No Cause of Death? _____ Father living? ☐ Yes ☐ No Cause of Death? _____

Grandmother living? ☐ Yes ☐ No Cause of Death? _____ Grandfather living? ☐ Yes ☐ No Cause of Death? _____

Does anything run in your family? (ex. 3 aunts had breast cancer) _____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current occupation _____ Who lives at home with you? _____

HABITS

Have you ever used tobacco? ☐ Yes ☐ No Do you use now? ☐ Yes ☐ No Do you want help quitting? ☐ Yes ☐ No

Maximum number of packs per day? _____ Age started: _____ Age quit: _____

Number of cups of coffee or caffeine beverages per day: _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____ How many drinks? _____

Do you exercise? ☐ Yes ☐ No How often? _____ What type? _____

Do you follow any special diet? ☐ Yes ☐ No What type? _____

Do you wear seatbelts? ☐ Yes ☐ No How often? _____

Do you do self-exam? (breast or testicular) ☐ Yes ☐ No

Are you at risk for HIV infection? ☐ Yes ☐ No

CONTINUED ON BACK

Please enter the dates of the following:

EVERYONE	Date	MEN ONLY	Date
Last colonoscopy? (applies to everyone over 50 or those who are high risk such as those with family history of colon polyps or colon cancer).		For those who are 65-75 and have smoked more than 100 cigarettes in a lifetime: have you been screened for abdominal aortic aneurysm?	
Last Cholesterol screen?			
Last Tetanus vaccine?		WOMEN ONLY	
Received the Shingles vaccine?		Do you have a gynecologist?	
Last pneumovax (vaccine to prevent pneumonia)?		Last mammogram?	
Hepatitis A *		Last Pap smear?	
Hepatitis B **		Last osteoporosis screening?	
Syphilis ***			
Meningococcal ****		PATIENTS WITH DIABETES	
HPV Vaccine *****		Last had eyes checked?	
Born between 1945-1965 Screened for Hepatitis C			

* Hepatitis A vaccine. Applies to ages over 19 for those with the following: pregnant, immune compromised (e.g., HIV, had chemotherapy, no spleen), men of have sex with men, those with heart or lung or liver or kidney disease, those with alcoholism or diabetes, health personnel. Two doses separated by at least 6 months.
** Hepatitis B vaccine. Applies to ages over 19 for those with the following: pregnant, Immune compromised (e.g., HIV, had chemotherapy, no spleen), men of have sex with men, those with heart or lung or liver or kidney disease, those with alcoholism or diabetes, health personnel. Three doses: 2nd one is given one month after the first dose, 3rd dose is given 4 months after the first dose.
*** Syphilis testing is advised for those with high risk behavior which includes men who have sex with men and engage in high-risk behavior; sex workers; those in adult correctional facilities; those with other sexually transmitted infections. If you are interested please ask, you do not have to say why.
**** Meningococcal vaccine. Applies to ages over 19 who have risk factors as follows: pregnant, Immune compromised (e.g., HIV, had chemotherapy, no spleen), men of have sex with men, those with heart or lung or liver or kidney disease, those with alcoholism or diabetes, health personnel. One dose.
***** Human papillomavirus vaccine. Applies to non-pregnant women 19-26 years old and men 19-21 years old, also to men 22-26 who have sex with men.

DO YOU NOW HAVE ANY OF THESE SYMPTOMS?

	YES	NO
GENERAL		
FEVER OR CHILLS / FEVERISH		
WEIGHT CHANGE		
NIGHT SWEATS		
EYES		
DOUBLE VISION		
LIMITED SIDE VISION		
EYE PAIN		
EARS, NOSE, THROAT		
HEARING LOSS		
EAR PAIN		
SINUS PAIN		
NOSE BLEEDS		
VERTIGO		
HOARSENESS		
FREQUENT SORE THROAT		
MOUTH ULCERS		
CARDIOVASCULAR		
CHEST PAIN OR TIGHTNESS		
IRREGULAR HEARTBEAT		
FAINTING & PASSING OUT		
LEG CRAMPS WHEN WALKING		
SWOLLEN ANKLES OR FEET		
SHORTNESS OF BREATH WHEN LYING DOWN		
RESPIRATORY		
COUGH		
COUGH WITH BLOODY PHLEGM		
SHORTNESS OF BREATH		
GASTROINTESTINAL		
DIFFICULT OR PAINFUL SWALLOWING		
DAILY HEARTBURN		
ABDOMINAL PAIN		
NAUSEA		
VOMITING		
CONSTIPATION		
DIARRHEA		
RECTAL BLEEDING		
BLACK STOOLS		
ENDOCRINE		
INTOLERANCE TO HEAT		
INTOLERANCE TO COLD		
INCREASED THIRST		

	YES	NO
URINARY		
PAINFUL URINATION		
SLOW URINE STREAM		
URINATION AT NIGHT		
BLOOD IN URINE		
URINE LEAKAGE OR INCONTINENCE		
MALE SYMPTOMS		
IMPOTENCE (ERECTILE DYSFUNCTION)		
TESTICLE SWELLING OR PAIN		
FEMALE SYMPTOMS		
VAGINAL DISCHARGE		
PAINFUL MENSTRUAL PERIODS		
IRREGULAR VAGINAL BLEEDING		
VAGINAL DRYNESS		
BREASTS		
TENDERNESS OR PAIN		
LUMPS		
NIPPLE DISCHARGE OR RASH OR OTHER SKIN CHANGE		
SKIN		
WORRISOME SPOTS OR GROWTHS		
PERSISTENT ITCHING		
SORE THAT DOES NOT HEAL		
RASHES		
MUSCULOSKELETAL		
JOINT PAIN WHERE?		
PAIN WHERE? NECK / LEG		
NEUROLOGICAL		
FREQUENT HEADACHES		
NUMBNESS WHERE? ARMS / HANDS LEGS / FEET		
MUSCLE WEAKNESS		
POOR COORDINATION / FALLS		
TREMOR OR SHAKING		
MEMORY LOSS		
PSYCHIATRIC		
DEPRESSION		
EXCESSIVE DAYTIME SLEEPINESS		
ANXIETY		
CHRONIC INSOMNIA		
HEMATOLOGIC/LYMPHATIC		
SWOLLEN GLANDS OR LYMPH NODES		
EASY BLEEDING OR BRUISING		