

CAROLINA MEDICAL CONSULTANTS, P.A.

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ TODAY'S DATE: _____

1. PRESENT HEALTH PROBLEMS OR REASON FOR EXAMINATION:

2. GENERAL INFORMATION:

IS YOUR HEALTH: GOOD FAIR POOR (PLEASE CIRCLE ONE)

PERSONAL HABITS:

DO YOU SMOKE? YES NO DID YOU EVER SMOKE? YES NO
CIGARETTES _____ PIPE _____ CIGAR _____

HOW MUCH? _____ HOW LONG? _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MUCH DAILY? _____

DO YOU EXERCISE REGULARLY? YES NO

WHAT TYPE AND HOW OFTEN? _____

LIST ANY DRUG ALLERGIES OR REACTIONS TO MEDICATIONS:

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION, OVER-THE-COUNTER, OR DIETARY SUPPLEMENTS):

3. PLEASE LIST ALL OPERATIONS AND DATES:

4. PLEASE LIST ANY ILLNESSES OR CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST OR ARE CURRENTLY BEING TREATED FOR:

5. FAMILY HISTORY:

- YES NO HAVE ANY CLOSE RELATIVES HAD DIABETES?
 YES NO HAVE ANY CLOSE RELATIVES HAD COLON POLYPS OR COLON CANCER?
 YES NO HAVE ANY CLOSE RELATIVES HAD ANY FORM OF CANCER?
 YES NO HAVE ANY CLOSE RELATIVES HAD SEVERE ALLERGIC PROBLEMS?
 YES NO HAVE ANY CLOSE RELATIVES HAD SICKLE CELL DISEASE?
 YES NO HAVE ANY CLOSE RELATIVES HAD HEART ATTACKS, HIGH BLOOD PRESSURE, STROKES OR HARDENING OF THE ARTERIES?
 YES NO HAVE ANY CLOSE RELATIVES LIVED EIGHTY YEARS OR MORE?
 YES NO HAVE ANY CLOSE RELATIVES DIED BEFORE THE AGE OF 60?
 YES NO IS YOUR MOTHER LIVING? IF NO, PLEASE STATE THE CAUSE OF DEATH:

YES NO IS YOUR FATHER LIVING? IF NO, PLEASE STATE THE CAUSE OF DEATH:

6. SYSTEM REVIEW: PLEASE INDICATE WHETHER YOU HAVE HAD ANY SIGNIFICANT PROBLEMS WITH THE FOLLOWING:

A. HEENT

- YES NO GLAUCOMA
 YES NO POOR VISION OR RECENT CHANGE
 YES NO CATARACTS
 YES NO RECURRENT DIZZINESS OR LIGHT-HEADEDNESS
 YES NO DIFFICULTY HEARING
 YES NO RINGING IN EARS
 YES NO HAY FEVER
 YES NO POSTNASAL DRIP
 YES NO FREQUENT SINUS INFECTIONS
 YES NO CHRONIC HOARSENESS (LASTING SEVERAL WEEKS)

B. RESPIRATORY--CARDIOVASCULAR

- YES NO ASTHMA OR RECURRENT WHEEZING
 YES NO CHRONIC COUGH OR EMPHYSEMA
 YES NO TUBERCULOSIS
 YES NO HIGH BLOOD PRESSURE
 YES NO ANGINA
 YES NO HEART ATTACK
 YES NO CHEST PAIN, TIGHTNESS, PRESSURE OR SQUEEZING OR BURNING IN THE CHEST DURING EXERTION OR AFTER MEALS
 YES NO PALPITATIONS, RACING OR IRREGULAR HEART BEAT
 YES NO DIFFICULTY BREATHING WITH ACTIVITY
 YES NO DIFFICULTY BREATHING AT REST
 YES NO RHEUMATIC FEVER OR HEART MURMUR
 YES NO LEG PAIN WHILE RESTING OR WITH EXERCISE
 YES NO VARICOSE VEINS OR SWELLING IN LEGS OR FEET

C. GASTROINTESTINAL

- YES NO POOR OR EXCESSIVE APPETITE
- YES NO WEIGHT GAIN OR WEIGHT LOSS
- YES NO FREQUENT INDIGESTION
- YES NO FREQUENT NAUSEA OR VOMITING
- YES NO FREQUENT HEARTBURN
- YES NO DIFFICULTY SWALLOWING
- YES NO SEVERE PAINS IN THE ABDOMEN
- YES NO STOMACH OR DUODENAL ULCERS
- YES NO REGURGITATION OF FOOD OR ACID AFTER BIG MEALS, WHEN BENDING OVER OR LYING DOWN
- YES NO VOMITED BLOOD
- YES NO HAD GALLSTONES
- YES NO PASSED BLOOD IN THE STOOL OR NOTED BLACK OR TARRY STOOLS
- YES NO FREQUENT LOOSE STOOLS, DIARRHEA
- YES NO CHRONIC CONSTIPATION
- YES NO HAD GAS OR INDIGESTION
- YES NO HAVE YOU HAD A COLON POLYP OR COLON CANCER
- YES NO HEMORRHOIDS
- YES NO JAUNDICE, LIVER OR GALLBLADDER DISEASE OR HEPATITIS

D. GENITOURINARY

- YES NO KIDNEY OR BLADDER INFECTIONS
- YES NO BLOOD IN URINE
- YES NO FREQUENT, PAINFUL, OR DIFFICULTY URINATING
- YES NO INABILITY TO CONTROL URINE
- YES NO HISTORY OF KIDNEY STONES
- YES NO VENEREAL DISEASE
- YES NO DIFFICULTY WITH SEXUAL FUNCTION
- YES NO PAIN DURING INTERCOURSE
- YES NO MEN: HISTORY OF PROSTATE TROUBLE, DIFFICULTY STARTING STREAM, OR DOUBLE VOID
- YES NO WOMEN: DIFFICULTY WITH PERIODS: EXCESSIVE FLOW, IRREGULAR OR UNUSUALLY PAINFUL
- YES NO ABNORMAL PAP SMEAR; DATE OF LAST PAP SMEAR: _____

IF POSTMENOPAUSAL, DATE OF MENOPAUSE: _____

NUMBER OF PREGNANCIES: _____ NUMBER OF CHILDREN: _____

PLEASE LIST ANY PROBLEMS WITH PREGNANCIES:

E. MUSCULOSKELETAL

- YES NO HISTORY OF ARTHRITIS
- YES NO PAINFUL OR SWOLLEN JOINTS
- YES NO HISTORY OF BACK PROBLEMS, INJURY OR PAIN
- YES NO DIFFICULTY WITH PAIN OR WEAKNESS IN MUSCLES
- YES NO OSTEOPOROSIS/BRITTLE BONES WITH FRACTURES

F. GENERAL

- YES NO DO YOU HAVE ANY CHRONIC OR SEVERE SKIN PROBLEMS
- YES NO HISTORY OF STROKE OR SEIZURES
- YES NO FAINTING OR DIZZY SPELLS
- YES NO MIGRAINE HEADACHES
- YES NO SEVERE HEAD INJURIES OR KNOCKED UNCONSCIOUS
- YES NO CHRONICALLY TIRED OR NO ENERGY
- YES NO DO YOU HAVE SPELLS OF DEPRESSION OR HOPELESSNESS
- YES NO DO YOU HAVE "NERVES" OR FEEL ANXIOUS
- YES NO DO YOU WORRY ABOUT A LOT OF DIFFERENT THINGS
- YES NO DO YOU HAVE DIFFICULTY SLEEPING
- YES NO DO YOU WAKE UP REFRESHED AND RESTED MOST MORNINGS?
- YES NO DO YOU HAVE PERIODS OF DAYS OR WEEKS WHEN YOU COULDN'T GET GOING?
- YES NO DO YOU FEEL YOUR EATING IS OUT OF CONTROL
- YES NO IS ANYONE PLOTTING AGAINST YOU
- YES NO DOES IT SEEM NO ONE UNDERSTANDS YOU
- YES NO EVEN WHEN YOU ARE WITH PEOPLE, DO YOU FEEL LONELY MUCH OF THE TIME
- YES NO DO YOU HAVE CRYING SPELLS
- YES NO HAVE YOU SOUGHT OR HAD PSYCHIATRIC HELP
- YES NO DO YOU HAVE DIABETES OR AN ABNORMAL BLOOD SUGAR
- YES NO DO YOU HAVE THYROID TROUBLE
- YES NO DO YOU HAVE EXCESS THIRST
- YES NO WOMEN: HAVE YOU EVER HAD A MAMMOGRAM?
- YES NO WHEN WAS YOUR LAST MAMMOGRAM? _____
- YES NO WOMEN: DO YOU HAVE BREAST PAIN, ABNORMAL LUMPS, OR DRAINAGE FROM BREAST?

DURING THE PAST MONTH.....

- YES NO HAVE YOU HAD AN ANXIETY ATTACK (SUDDENLY FEELING FEAR OR PANIC)
- YES NO HAVE YOU THOUGHT YOU SHOULD CUT DOWN ON YOUR DRINKING OF ALCOHOL
- YES NO HAS ANYONE COMPLAINED ABOUT YOUR DRINKING
- YES NO HAVE YOU FELT GUILTY OR UPSET ABOUT YOUR DRINKING
- YES NO WAS THERE EVER A SINGLE DAY IN WHICH YOU HAD 5 OR MORE DRINKS OF BEER, WINE, OR LIQUOR

OVERALL, WOULD YOU SAY YOU HEALTH IS:

- EXCELLENT
- VERY GOOD
- GOOD
- FAIR
- POOR