CMC – Elizabeth Family Medicine

Carolinas HealthCare System

Name _____

Date of Birth _____

Employer _____

Occupation _____

Education (Highest Grade) _____

Who Was Your Previous Physician _____

How Did You Hear About The Family Practice Center? _____

Have You Had Any Of The Following Disorders?

Problem	No	Yes	If so, When and Where?
Stroke			
Diabetes			
Tuberculosis			
Seizures			
High Blood Pressure			
Heart Trouble			
Pneumonia and/or Lung Disease			
Asthma			
Cancer			
Ulcer or Bleeding from Stomach			
Gall Bladder Trouble			
Arthritis Or Other Joint Disease			
Anemia			
Allergies To Medication			
Other Problems			

List Any and All Medications That You Take Prescription And Non-Prescription

_____

_____

_____

List All Previous Surgeries

_____

_____

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