Carolinas HealthCare System

PATIENT MEDICAL HISTORY

VACCINES	APPROXIMATE DATE	EXAMS	APPROXIMATE DATE/PROVIDER or LOCATION
Tetanus	_____	Last Dental Exam	_____
Flu	_____	Last Eye Exam	_____
Hepatitis B	_____	Last Colonoscopy	_____
Pneumovax	_____	Last Mammogram	_____
Prevnar	_____	Last Pap Smear	_____
Zostavax	_____	Last Physical Exam	_____
Other:_____	_____	Last Bone Density	_____

Past Medical History: Mark Yes for Family that are blood relatives	No	Yes	Family (Yes)		No	Yes	Family (Yes)
Anemia				Tuberculosis			
Easy Bruising				Seizures-Epilepsy			
Leukemia				Stroke/TIA			
Recurrent Infections				Mental Illness			
Arthritis				Diabetes			
Heart Disease				Gout			
High Blood Pressure				Thyroid Trouble			
High Cholesterol				Peptic Ulcers			
Kidney Disease				Colon (Bowel) Disease			
Asthma				Cancer			
Emphysema				Hepatitis			
Severe Allergies				Liver Disease			
Measles				Rheumatic Fever			
Mumps				Scarlet Fever			
Chicken Pox				Venereal Disease			
Have close contact w/ children under 4 years of age?				Other			
Other				Other			
Other				Other			

List all medications you are presently taking. (Prescriptions or not) and how often you take them (include laxatives, aspirins, antacids, birth control pills, over-the-counter Meds/Vitamins etc.)

_____

_____

_____

_____

_____

_____

_____

Patient Name:_____
DOB: _____
MRN#_____

Medical Associates of Rock Hill
and
Medical Associates of Fort Mill

Are you allergic to any medicine? ☐ YES ☐ NO List all medications and reactions

_____

_____

_____

_____

Please list all past surgeries. (List all – Tonsils, Appendix, Hysterectomy, Gallbladder, etc.)

_____

_____

_____

_____

_____

_____

DO YOU	YES	NO	TYPE	AMT./DAY	DATE QUIT
Use or used tobacco products	☐	☐			
Use e-cigs	☐	☐			
Consume alcohol	☐	☐			
Drink Caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise Regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside of the US	☐	☐			

FEMALES ONLY:

Age when 1st period began:

Age when you stopped having periods:

Date of 1st day of last menstrual period:

Duration of period (days):

Do you have problems with your period?

Number of children:

Number of miscarriages:

Number of abortions:

Do you have any breast problems? (pain, lumps, discoloration, etc.):

Have you had a hysterectomy?

Name of GYN/OB if applicable:

Date: ___/___/____ Signature:_____

Emergency Contact/Relationship: _____

Address: _____

Phone Number: _____

Patient Name:_____

DOB: _____

MRN#_____

Medical Associates of Rock Hill
and
Medical Associates of Fort Mill