Carolinas HealthCare System

South Charlotte Primary Care
7030 Pineville Matthews Road • Charlotte, NC 28226
Internal Medicine (704) 667-4150 • Pediatrics (704) 667-4130
Fax (704) 752-7040

MEDICAL HISTORY

Date ____________ Age ____________
Physician ________________________

Name ________________________ Referring Physician ________________

Current Occupation ________________________

Operations (Give approximate date)

Tonsillectomy ____________ Hysterectomy ____________ Gallbladder ____________
Hernia Repair ____________ Hemorrhoidectomy ____________ Biopsy ____________
Appendectomy ____________ Ulcer Surgery ____________ Joint Surgery ____________
Other ____________

Other Hospitalizations or Accidents ________________________

Radiation Therapy

Allergies: Drugs ________________________
Asthma ____________ Hay Fever ____________ Hives ____________

Habits: Tobacco Use ____________ Alcohol Use ____________
Caffeine (coffee, tea, cola) ____________ Milk ____________
Daily Exercise ____________ Seat Belts ____________

Family History

Father: Age ____________ Health or cause of death ____________
Mother: Age ____________ Health or cause of death ____________
Number of Brothers ____________ Number of Sisters ____________
Age and State of Health of Spouse ____________ Occupation of Spouse ____________
Number of Children ____________

Have any of your close relatives (parents, grandparents, brothers, sisters) had:

Diabetes ________ Tuberculosis ________ Cancer ________ Allergic Diseases ________
Heart Disease ________ Arthritis ________ Bleeding Diseases ________ Psoriasis ________
High Blood Pressure ________ Chronic Back Pain ________
Do other diseases occur in your family? ________________________

Immunizations

Tetanus ________ Polio ________ Diphtheria ________ Others ________

For Women

Pregnancies ________ Miscarriages ________ Living Children ________
Age at onset of Periods ________ Interval ________ Duration ________
Date of Last Period ________ Irregular Periods? ________ Spotting between Periods? ________
Age at Menopause ________

Have You Ever Had Any of the Following Problems?

	YES	*NO*		*YES*	*NO*		*YES*	*NO*
Heart Disease			Tuberculosis			Kidney Stones		
High Blood Pressure			Positive TB Skin Test			Cancer		
Rheumatic Fever			Stomach Ulcer			Stroke		
Heart Murmur			Hepatitis			Convulsions		
Enlarged Heart			Gallstones			Phlebitis		
Pneumonia			Thyroid Trouble			Bleeding Disorder		
Pleurisy			Diabetes			Venereal Infection		

Military Service ________________________ How Many Years? ________________

CURRENT HEALTH
Current Medications

Vitamins ____________ Laxatives ____________ Birth Control Pills ____________

Others ____

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Do You Now Have Any of the Following Problems?

	YES	NO
Fever	☐	☐
Skin Rash	☐	☐
Swollen Glands	☐	☐
Eye Problems	☐	☐
Ear Problems	☐	☐
Recurring Nosebleeds	☐	☐
Persistent Hoarseness	☐	☐
Goiter	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Frequent Coughing	☐	☐
Coughing up Blood	☐	☐
Chest Pain or Pressure	☐	☐
Swelling of Ankles/Feet	☐	☐
Irregular Heart Beat	☐	☐

	YES	NO
Trouble with Swallowing	☐	☐
Frequent Indigestion	☐	☐
Abdominal Pain	☐	☐
Vomiting Blood	☐	☐
Frequent Constipation	☐	☐
Frequent Diarrhea	☐	☐
Change in Bowel Habits	☐	☐
Bloody Bowel Movements	☐	☐
Slow Urinary Stream	☐	☐
Blood with Urination	☐	☐
Frequent Urination at Night	☐	☐
Painful Urination	☐	☐
Painful or Swollen Joints	☐	☐
Frequent Backache	☐	☐

	YES	NO
Any Weakness of Arm or Leg	☐	☐
Frequent Dizziness	☐	☐
Any Fainting Spells	☐	☐
Frequent Headaches	☐	☐
Double Vision	☐	☐
Unusual Worry or Depression	☐	☐
Recent Weight Change (3 mo.)	☐	☐
Other	☐	☐

When Did You Last Have These Tests?

Electrocardiogram ____________

Chest X-Ray ____________

Mammogram ____________

Blood Tests ____________

Urine Test ____________

Pelvic Exam ____________

Rectal Exam ____________

Stool Test for Blood ____________

Colon Scope Test ____________

What is the Main Reason for Your Visit to the Doctor?