CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

Carrboro Family Medicine Center, P.A.
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Patient Information

Patient's Name_____ **Chart Number**_____ **Sex**: Male or Female
Last Name First Name MI

What name do you prefer to be called by? _____

Why did you make this appointment to see us today? _____

Occupation_____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Seperated ❒ Widowed

Past Medical History

What chronic or previous medical problems have you had? Please list date of initial diagnosis below:

❒ High blood pressure If yes, what have your blood pressures been? _____

❒ Diabetes If yes, what have your blood sugars been? _____

❒ Heart disease, heart surgery, or stroke _____

❒ Chronic lung, kidney, liver, or thyroid disease? List disorder and date _____

❒ Gastrointestinal problems? List disorder and date _____

❒ Back problems? List disorder and date _____

❒ Mental illness? List disorders and dates _____

❒ Drug or alcohol dependency? What substances? _____

❒ Do you follow any special diet (such as low cholesterol, diabetic, etc.). Describe _____

❒ Cancer If yes, list disease and date _____

❒ Fractures (broken bones)? _____

❒ Any other chronic illness or disability? _____

What other medical providers do you see? List name and reason _____

Allergies

Are you allergic to any medications, plants, pollen, foods, or other items? Please list and state reaction : _____

_____

_____

PLEASE CONTINUE TO THE NEXT PAGE OF THIS FORM

Patient's Name_____ **Chart Number** _____
Last Name First Name MI

Family History

Please check the appropriate boxes if any blood relative had these diseases, list their relationship to you (siblings, parents, grandparents, aunts, uncles), whether paternal or maternal, and the age of onset.

- ❒ Glaucoma
- ❒ Diabetes
- ❒ Hypertension
- ❒ Sudden Death
- ❒ Stroke
- ❒ TIA (mini strokes)
- ❒ Heart attack
- ❒ Coronary artery disease, Angina
- ❒ Heart bypass surgery
- ❒ Coronary balloon angioplasty/stent
- ❒ Abdominal aortic aneurysm
- ❒ Osteoporosis or Hip fracture
- ❒ Depression
- ❒ Colon polyps
- ❒ Colon cancer
- ❒ Melanoma
- ❒ Prostate cancer
- ❒ Breast cancer
- ❒ Cervical cancer D Ovarian cancer
- ❒ Uterine cancer

Social History

YES **NO**

___ ___ Do you smoke/ever smoked? Never _____ Packs per day? _____ Year started _____ Year quit _____

___ ___ Do you use other forms of tobacco or electronic cigarettes? Which ones? _____

___ ___ If you use tobacco, are you ready to quit?

___ ___ Do you drink alcohol? How many drinks per day _____, or per week_____, of what ?_____

___ ___ Do you drink caffeine? How many drinks per day? _____ What beverage? _____

___ ___ Do you use illicit or recreational drugs? Whkh ones and how often? _____

Medications

List current medications, over-the-counter drugs, herbs, and supplements. List dose and frequency of administration:

_____

_____

_____

Past Surgical History

Please list any past surgeries and dates:

- ❒ Appendectomy
- ❒ Back surgery
- ❒ Breast biopsy
- ❒ Cataract removal
- ❒ C-section
- ❒ Cholecystectomy
- ❒ Eye surgery
- ❒ GYN surgery
- ❒ Heart bypass/angioplasty
- ❒ Hernia repairs
- ❒ Tonsillectomy
- ❒ Tubal ligation
- ❒ Vasectomy
- ❒ Wisdom teeth
- ❒ Other surgeries or Hospital

Diagnostic Procedures History

Have you had any diagnostic procedures in the past? (treadmill or other heart tests, x-rays or scans, upper or lower endoscopy, etc.)

Please list procedure and date _____

Do you have a living will?_____ Healthcare power of attorney?_____ Would you like to discuss this today? _____

Is there anything else that you want to ask your healthcare provider today? _____