



South Charlotte Primary Care

Carolinas HealthCare System

7030 Pineville Matthews Road • Charlotte, NC 28226

Internal Medicine (704) 752-7050 • Pediatrics (704) 752-7000

Fax (704) 752-7040

MEDICAL HISTORY

Name _____ Date _____ Age _____

Physician _____

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 _____ Hives _____

Asthma _____ Hay Fever _____

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

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 _____

Do You Now Have Any of the Following Problems?

	YES	NO	YES	NO	YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Any Weakness of Arm or Leg ... <input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Dizziness
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Any Fainting Spells
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision
Recurring Nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Worry or Depression .. <input type="checkbox"/>
Persistent Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change (3 mo.)... <input type="checkbox"/>
Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Bowel Movements.....	<input type="checkbox"/>	<input type="checkbox"/>	Other
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Slow Urinary Stream	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Blood with Urination	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination at Night ..	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing up Blood.....	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain or Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful or Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of Ankles/Feet ..	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Backache	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>				

When Did You Last Have These Tests?

Electrocardiogram _____	Blood Tests _____	Rectal Exam _____
Chest X-Ray _____	Urine Test _____	Stool Test for Blood _____
Mammogram _____	Pelvic Exam _____	Colon Scope Test _____

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