Carolina Family Healthcare

1932 Weddington Rd, Weddington, NC 28104
11220 Elm Lane, Suite #102, Charlotte, NC 28277

Health History Confidential

Name_____ Today's date_____

Age_____ Birth date_____ Date of Last Physical Exam_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE)

Acid Reflux (GERD)
Anemia
Angina
Arthritis: Type
Attention Deficit Disorder
Asthma
Blood Transfusion
Cancer: Type
Chronic Fatigue Syndrome
Chemical/Drug Dependency
Clotting Disease
Colitis
COPD/Emphysema
Crohns/Ulcerative Colitis
Diabetes
Fibromyalgia
Glaucoma
Gout
Hearing Problem
Heart Attack/Heart Disease
Heart Murmur
High Blood Pressure
High Cholesterol
Hiatal Hernia
HIV/AIDS
Irritable Bowel Syndrome (IBS)
Kidney Disease
Kidney Stones
Liver Disease
Lyme Disease
Multiple Sclerosis
Macular Degeneration
Phlebitis
Pneumonia
Positive TB Test
Retinosa Pigmentosa
Rheumatic Fever
Seizure
Sexually Transmitted Disease (STD)
Skin Disease: Type
Stroke
Thyroid Disease: Type

Date of Your Last Colonoscopy: _____

Any Other Significant Medical Condition(s): _____

FOR WOMEN ONLY

Date of Last Pap Smear: _____ Date of Last Period: _____ Any Abnormal Pap Smears? **Y or N** If Yes, When? _____

Do you suffer with PMS? **Y or N** Are your periods painful? **Y or N** How long do your periods last? _____

Do you feel you are having any menopausal symptoms? **Y or N** If Yes, please list your symptoms: _____

Have you ever had your Hemocysteine level checked?

FOR MEN ONLY

Have you had your PSA level checked? **Y or N** If Yes, when? _____ Level at Last Test: _____

Have you ever had your male hormone level checked? **Y or N** If Yes, when? _____ Results: _____

Do you have Erectile Dysfunction? **Y or N** Have you ever had your Homocysteine level checked? **Y or N**

MEDICATIONS List Medications, Dosage & Frequency you are currently taking	**Allergies** To Medications Or Substances

SUPPLEMENTS & VITAMINS List Supplements, Dosage & Frequency you are currently taking

PLEASE COMPLETE PAGE 2 AND SIGN AT THE BOTTOM

FAMILY HISTORY
Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

√	DISEASE	RELATIONSHIP
	Arthritis, Gout	
	Asthma	
	Chemical Dependency	
	Diabetes, Cancer	
	Heart Disease, High Blood Pressure	
	High Cholesterol	
	Kidney Disease, Strokes	
	Other:	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization & Outcome

ALL ILLNESSES/INJURIES	DATE	OUTCOME

Other Information:

PREGNANCY HISTORY

Year	Sex	Complications

MARITAL STATUS: _____

HEALTH HABITS
√ Which Substances You Use and Describe How Much You Use Per Day.

	Caffeine
	Tobacco _____Packs Per Day _____Quit Date
	Drugs
	Alcohol

WORK and EXERCISE
√ Your Amount

Mental Work	☐Light ☐Mod ☐Heavy Hours/Day_____
Physical Work	☐Light ☐Mod ☐Heavy Hours/Day_____
Exercise	☐Light ☐Mod ☐Heavy Hours/Day_____

OCCUPATIONAL CONCERNS
√ If your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____ Reviewed by _____ Date _____