Carolinas HealthCare System

Riverbend Family Practice

Patient History

Today's Date _____ Chart # _____

MRN # _____

Name: _____ Age: _____ Date of Birth _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse/Significant Other Name: _____ Education: Highest Level Completed _____

Vaccines	Approximate Date	Exams	Approximate Date
Tetanus		Last Dental exam	
Flu		Last Eye exam	
Hep B		Last Chest X-ray	
Pneumovax		Last Colonoscopy/Sigmoidoscopy	
MMR		Last Mammogram	
Chicken pox		Last Pap Smear	
TB skin Test Positive Negative		Last Physical Exam	
		Last Prostate Exam/PSA	
		Other _____	

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease		Rheumatic fever	
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*		Stomach/Intestinal disorders	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*		Gallbladder disorders	
Stroke		Thyroid disorders *(goiter)*	
High Blood Pressure		Gout	
Diabetes		Skin disorders	
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*		Depression or other Mental Illness	
Kidney disorders *(including kidney stones)*		Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Arthritis		Alcohol/Drug abuse	
Blood disorders *(anemia, bleeding disorders, etc.)*		Risk factors for HIV	
High Cholesterol		Migraines/Headaches	
Allergies *(food, seasonal)*		Other _____	

Current Medications – Prescription and Over-The-Counter Meds. ***(including vitamins, herbs, aspirin, antacids, injectables, hormones)***	**Are you allergic to any medicine?** ☐ **Yes** ☐ **No** **Please list all medications and reactions**
	Operations:
Specialist:	Year: Reason:
	Hospitalizations:
	Year: Reason:

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

See Reverse Side

INDICATE WHICH APPLY TO YOU

PAST MEDICAL HISTORY	Yes	No
1. Hypertension	☐	☐
2. High Cholesterol	☐	☐
3. Heart Disease	☐	☐
4. Heart Valvular Disease	☐	☐
5. Heart Rhythm Disturbance	☐	☐
6. Depression/Anxiety	☐	☐
7. Substance Abuse (Type)_____	☐	☐
8. Bipolar Disorder	☐	☐
9. Suicide Attempts	☐	☐
10. Osteoarthritis	☐	☐
11. Peripheral Vascular Disease	☐	☐
12. COPD/Emphysema	☐	☐
13. Asthma	☐	☐
14. Diabetes	☐	☐
15. Thyroid Disease	☐	☐
16. Peptic Ulcer/Reflux	☐	☐

PAST MED. HISTORY (cont.)	Yes	No
17. Ulcerative Colitis/Crohn's	☐	☐
18. Cirrhosis	☐	☐
19. Hepatitis	☐	☐
20. Seizures	☐	☐
21. Migraines	☐	☐
22. Alzheimers/Dementia	☐	☐
23. Rheumatic Disease	☐	☐
24. Fibromyalgia	☐	☐
25. Osteoporosis	☐	☐
26. Sexually Tr. Disease (Type) _____		
27. Endometriosis	☐	☐
28. Birth Control (Type) _____		
29. Preg ____ Births _____ Ab/Miscarriage ___		
30. Abnormal Pap	☐	☐
31. Abnormal Mammogram	☐	☐
32. Prostate Disease	☐	☐

PAST MED. HISTORY (cont.)	Yes	No
33. Cancer (Type) _____	☐	☐
34. Kidney Stones	☐	☐
35. Kidney Failure	☐	☐

PAST SURGICAL HISTORY / SERIOUS INJURIES	Yes	No
1. Appendix	☐	☐
2. Gallbladder	☐	☐
3. Tonsillectomy	☐	☐
4. Blood Transfusions	☐	☐
5. Heart/Vessel Surgery	☐	☐
6. Hysterectomy/Ovaries Removed	☐	☐
7. Hernia Repair	☐	☐
8. Motor Vehicle Accidents	☐	☐
9. Trauma	☐	☐
10. Fractures	☐	☐
11. Missing Organs/Extremities	☐	☐
12. Other _____		

GENERAL	Yes	No
1. Fever/night sweats	☐	☐
2. Frequent infections	☐	☐
3. Weight change	☐	☐
4. Appetite/thirst change	☐	☐
5. Excessive fatigue/nervousness	☐	☐
6. Difficulty sleeping	☐	☐
7. Enlarged/tender lymph nodes or glands	☐	☐
8. Other _____		

EYES	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Dry eyes	☐	☐
6. Other _____		

EARS	Yes	No
1. Hearing loss	☐	☐
2. Earaches	☐	☐
3. Ear drainage	☐	☐
4. Buzzing/ringing	☐	☐
5. Feel "stopped up"	☐	☐
6. Other _____		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Hoarseness	☐	☐
5. Changes in taste	☐	☐
6. Sleep apnea *(stop breathing while sleeping)*	☐	☐
7. Other _____		

PULMONARY	Yes	No
1. Shortness of breath/difficulty breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Other _____		

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL	Yes	No
1. Heartburn/indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Black stools	☐	☐
10. Changes in bowel habits	☐	☐
11. Frequent laxatives	☐	☐
12. Liver problems/jaundice/ hepatitis	☐	☐
13. Gallstones	☐	☐
14. Other _____		

BREAST	Yes	No
1. Lumps/pain/discharge	☐	☐
2. Other _____		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA _____		
8. Genital concerns	☐	☐
9. Other _____		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause/symptoms	☐	☐
7. Problems with pregnancies	☐	☐
8. Sexual difficulties	☐	☐
9. Do you use birth control Type _____	☐	☐
10. Date of last pap _____		
11. History of Abnormal Pap Treatment _____	☐	☐
12. Date of last mammogram _____		
13. Age at onset of periods _____		
14. Frequency of periods _____		
15. Last menstrual period _____		
16. Other _____		

MUSCULOSKELETAL	Yes	No
1. Joint pain/tenderness	☐	☐
2. Joint swelling/warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Other _____		

SKIN	Yes	No
1. Rashes	☐	☐
2. Bruising	☐	☐
3. Mole/lesion changes	☐	☐
4. Skin color changes	☐	☐
5. Skin growths	☐	☐
6. Hair/nail problems	☐	☐
7. Other _____		

NEUROLOGIC	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other _____		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Phobias	☐	☐
6. Other _____		

URINARY	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other _____		

Carolinas HealthCare System

HIPAA* Authorization Form

Patient Name: _____ DOB: _____

Do you agree to share information (lab results, medication requests, appointments, billing information, etc.) with anyone?

☐ No, I do not wish to share any information

☐ Yes (please fill in additional information)

Contact Name	Contact Number	Relationship	Comments

Signature: _____ Date: _____

Printed Name (if other than the patient): _____

Relationship: _____

** Health Insurance Portability and Accountability Act of 1996*