

DATE: \_\_\_\_\_

**CHARLOTTE MEDICAL CLINIC, INC.  
PATIENT HISTORY FORM**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

In order to serve you better and save you time, we would appreciate the following information (use extra pages if you need more room)

1. What is your chief complaint? \_\_\_\_\_  
\_\_\_\_\_
2. Who referred you to us? \_\_\_\_\_
3. What is your occupation? \_\_\_\_\_
4. How many years of schooling have you had? \_\_\_\_\_
5. Concerning your medical history:
  - a. How much do you smoke and for how long?  
\_\_\_\_\_
  - b. How much alcohol (beer, wine, mixed drinks) do you consume?  
\_\_\_\_\_
  - c. Do you exercise regularly? \_\_\_\_\_
  - d. Please list any allergies to drugs or other substances:  
\_\_\_\_\_  
\_\_\_\_\_
  - e. Do you feel you may have any risk factors for HIV Infection (AIDS)  
\_\_\_\_\_
  - f. Have you had any surgery? \_\_\_\_\_  
If so, what type of surgery, who performed the surgery, where and when it was done:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - g. Have you had any major illnesses? If yes, please tell us about them.  
\_\_\_\_\_  
\_\_\_\_\_
  - h. Any other overnight hospital stays: \_\_\_\_\_
  - i. Are you now taking any treatment (like allergy shots) or any medicines ( including non-prescription)? If so please list:  
\_\_\_\_\_  
\_\_\_\_\_

6. Family History:  
We are especially interested in any history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or attempted suicide. Please fill out the family history chart below:

	<b>AGE (S) IF LIVING</b>	<b>AGE (S) AT DEATH</b>	<b>STATE OF HEALTH OR CAUSE OF DEATH</b>
Father			
Mother			
Brother (s)			
Sister (s)			
Spouse			
Children			

7. If you have had any of the following tests or immunizations, please indicate the date when they were last done.

MAMMOGRAM \_\_\_\_\_  
FLU VACCINE \_\_\_\_\_  
PNEUMONIA VACCINE \_\_\_\_\_  
TETANUS SHOT \_\_\_\_\_  
COLON EXAM \_\_\_\_\_

ELECTROCARDIOGRAM \_\_\_\_\_  
CHEST X-RAY \_\_\_\_\_  
POLIO VACCINE \_\_\_\_\_  
TB SKIN TEST \_\_\_\_\_  
HEPATITUS VACCINE \_\_\_\_\_

(Sigmoidoscopy or colonoscopy)

**PLEASE COMPLETE PAGE 2 OF THIS FOR**

## REVIEW OF SYSTEMS

FILL IN THE BLANKS, OR CIRCLE NUMBERS WHERE YOU HAVE PROBLEMS:

### GENERAL

1. weight change
2. appetite change
3. well -being
4. difficulty sleeping
5. other\_\_\_\_\_

### DERMATOLOGIC

1. rashes
2. dry skin
3. bruises easily
4. sweating
5. itching
6. hair problems
7. nail problems
8. other\_\_\_\_\_

### ENDOCRINE & METABOLIC

1. sugar diabetes
2. goiter
3. thyroid problem
4. sterility
5. cholesterol/lipid problem
6. other\_\_\_\_\_

### HEMATOPOIETIC/LYMPHATIC

1. anemia
2. lymph node enlargement
3. bleeding problem
4. frequent infections
5. other\_\_\_\_\_

### EYES

1. change in vision
2. glasses/contacts
3. red eye
4. eye pain
5. glaucoma
6. other\_\_\_\_\_

### EARS

1. infections
2. earaches
3. discharge
4. buzzing
5. mastoid problems
6. hearing loss
7. dizziness and nausea
8. other\_\_\_\_\_

### NOSE & THROAT

1. sinusitis/nasal stuffiness
2. nose bleeds
3. sore throat
4. hoarseness
5. tonsillitis
6. taste change
7. teeth, gums
8. other\_\_\_\_\_

### PULMONARY

1. shortness of breath
2. cough
3. sputum
4. bronchitis
5. asthma
6. night sweats
7. other\_\_\_\_\_

### CARDIOVASCULAR

1. chest pain
2. heart attack
3. heart failure
4. edema
5. high blood pressure
6. palpitations (irregular heartbeat)
7. leg cramps with walking
8. other\_\_\_\_\_

### GASTROINTESTINAL

1. heartburn/indigestion
2. difficulty swallowing
3. stomach pains
4. ulcers
5. nausea/vomiting
6. diarrhea
7. hemorrhoids
8. rectal bleeding
9. black bowel movements
10. change in bowel habits
11. constipation
12. frequent laxatives
13. jaundice or hepatitis
14. liver trouble
15. gallbladder
16. other\_\_\_\_\_

### GENITO-URINARY

1. burning on urination
2. frequency of urination
3. difficulty starting urine
4. wets pants or bed
5. bloody urine

6. kidney stones
7. prostate trouble
8. sexual difficulties
9. venereal disease
10. other\_\_\_\_\_

### MUSCULOSKELETAL

1. joint pain
2. joint swelling or warmth
3. joint stiffness
4. muscle pain
5. weakness
6. back pain
7. joint deformity
8. other\_\_\_\_\_

### NEUROLOGIC

1. headaches
2. dizziness
3. blackouts
4. numbness and tingling
5. paralysis
6. convulsions/seizures
7. coordination trouble
8. other\_\_\_\_\_

### PSYCHIATRIC

1. anxiety
2. depression
3. other illness
4. has seen psychiatrist
5. other\_\_\_\_\_

### FEMALES

1. age at onset of periods\_\_\_\_\_
2. frequency of periods\_\_\_\_\_
3. last menstrual period\_\_\_\_\_
4. excessive flow
5. excessive pain
6. vaginal discharge
7. menopause
8. number of pregnancies\_\_\_\_\_
9. successful pregnancies\_\_\_\_\_
10. pregnancy complications
11. date of last pap test\_\_\_\_\_
12. other\_\_\_\_\_

### BREASTS

1. lumps
2. pain
3. discharge

### MISCELLANEOUS

1. coffee or tea (\_\_\_\_ cups per day)
2. marijuana or other drugs
3. doesn't use safety belts
4. industrial exposure

**SPECIAL PROBLEMS OR SYMPTOMS**

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