

PRIMARY MEDICAL CARE

270 Cornerstone Drive, Suite 105
Cary, NC 27519
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Today's Date: _____ 2020

Preferred Provider: Dr. Mackenzie [] Natasha Hofberg []
Date of Birth: _____

Name _____ Occupation _____

Sex: Male [] Female [] Other: _____
Orientation: Heterosexual [] Homosexual [] Bisexual [] Other: _____
Marital Status: Married [] Single [] Divorced [] Widowed [] Other: _____
Ethnicity/Race: Caucasian [] Asian [] African American [] Hispanic [] Other: _____
Preferred Language: English [] Spanish [] Other: _____

PAST MEDICAL HISTORY

List any chronic or recurrent health problems currently under treatment:

List any hospitalizations or operations such as: gallbladder[] appendectomy[] hysterectomy/uterus[] ovaries[] back[] neck[] sinuses[] tonsillectomy[] vasectomy[] tubal ligation[] C-section[]

Are you seeing any specialist or other primary care providers? [] yes [] no
What medications are you on? Blood Pressure [] Diabetes [] Cholesterol [] Anxiety [] Depression [] Sleep [] Asthma/Allergy [] Other: _____

Are you legally disabled? [] yes [] no Would you consider yourself financially vulnerable? [] yes [] no
Do you have an advance directive? [] yes [] no Do you feel safe in your home? [] yes [] no

Have you ever had: (Circle correct answers:)

Yes / No	Problems with eyes	Yes / No	Stomach Problems	Yes / No	ADD/Anxiety/Depression
Yes / No	Problems with ears	Yes / No	Liver Disease	Yes / No	Arthritis
Yes / No	Seizures	Yes / No	Diabetes	Yes / No	Anemia
Yes / No	High Blood Pressure	Yes / No	Migraines	Yes / No	Thyroid Problems
Yes / No	Heart stent [] angioplasty [] heart attack [] other []			Yes / No	Cancer
Yes / No	Kidney Problems stones [] other []			Yes / No	Asthma

Have you been diagnosed with a memory deficit disorder? [] yes [] no
Have you ever had an allergic reaction or a bad reaction to a prescription or over the counter medication, vaccination, food or dye?
Yes [] No [] If yes, to what? _____

Do any of your relatives have:

Yes / No	Seizures	Yes / No	Thyroid Problems	Yes / No	Substance Abuse
Yes / No	Stroke	Yes / No	Mental Illness	Yes / No	Arthritis
Yes / No	High Blood Pressure	Yes / No	Migraine Headaches	Yes / No	Diabetes (sugar)
Yes / No	Asthma/Lung Disease	Yes / No	Heart stent [] angioplasty [] heart attack [] other []		
Yes / No	Cancer breast [] colon [] other (specify) []				

Month/Year of Last Annual Physical: _____

Have you had a colonoscopy? [] No [] Yes When? _____

Current Smoker [] No [] Yes Former Smoker [] No [] Yes

Alcohol [] No [] Yes How much? _____ *Have you ever felt you should cut down on your drinking? Yes / No

Have you ever felt bad or guilty about your drinking? Yes / No Have people annoyed you by criticizing your drinking? Yes / No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)? Yes / No

Exercise [] >3 times/week [] 1-2 times/week [] rarely Any recreational drug or substance use [] No [] Yes

Last Tetanus Shot: _____ What kind? _____

of Children _____ Children's ages _____

Do you have any dietary restrictions or follow any special diet? (Ex. vegetarian) _____

Have you had a mammogram? [] No [] Yes When? _____
Have you had a pap? [] No [] Yes When? _____
of Pregnancies _____ C-section or vaginal birth? _____
Do you use birth control? [] No [] Yes What kind? Pill [] Condoms [] Tubal [] Vasectomy [] Other []

*Screening questions from CAGE assessment