PRIMARY MEDICAL CARE ***UPDOX TO HIPAA/INS 2025***

270 Cornerstone Drive, Suite 105
Cary, NC 27519
(919) 460-7676 (919) 460-4605 FAX

Today's Date: _____

Preferred Provider: Dr. Mackenzie ☐ Natasha Hofberg ☐

Date of Birth: _____

Name _____ **Occupation** _____

Gender Identity: Male ☐ Female ☐ Trans Man ☐ Tran Woman ☐ Genderqueer ☐ Other**:**_____ Declined ☐
Sexual Orientation: Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't know ☐ Other**:**_____ Declined ☐
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____ Declined ☐
Ethnicity/Race: White ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____ Declined ☐
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:)

Problems with eyes	**Stomach Problems**	**ADD/Anxiety/Depression**
Problems with ears	**Liver Disease**	**Arthritis**
Seizures	**Diabetes**	**Anemia**
High Blood Pressure	**Migraines**	**Thyroid Problems**
Heart stent ☐ angioplasty ☐ heart attack ☐ other ☐		**Cancer**
Kidney Problems stones ☐ other ☐		**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:

Seizures	**Thyroid Problems**	**Substance Abuse**
Stroke	**Mental Illness**	**Arthritis**
High Blood Pressure	**Migraine Headaches**	**Diabetes (sugar)**
Asthma/Lung Disease	**Heart** stent ☐ angioplasty ☐ heart attack ☐ other ☐	
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?**
Have you ever felt bad or guilty about your drinking? **Have people annoyed you by criticizing your drinking?**
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?
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?** _____

 *Screening questions from CAGE assessment