PRIMARY MEDICAL CARE

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** _____

Sex: Male[ ] Female[ ] **Marital Status:** Married[ ] Single[ ] Divorced[ ] Widowed[ ] Other[ ]
Sexual Orientation: Heterosexual[ ] Homosexual[ ] Bisexual[ ] Pansexual[ ] Transexual[ ] Other[ ]
Ethnicity/Race: Caucasian[ ] Asian[ ] African American[ ] Hispanic[ ] Other:_____
Native Language: English[ ] Other:_____ **Language Spoken In Home**: _____ **Preferred Language**: _____

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
If yes, what treatments are you receiving: _____

Are you legally disabled? [ ] yes [ ] no **Would you consider yourself financially vulnerable?** [ ] yes [ ] no

Have you ever had: (Circle correct answers)

Yes / No **Problems with eyes**
Yes / No **Problems with ears**
Yes / No **Asthma**
Yes / No **High Blood Pressure**
Yes / No **Heart** stent[ ] angioplasty[ ] heart attack[ ] other[ ]
Yes / No **Kidney Problems** stones[ ] other[ ]

Yes / No **Stomach Problems**
Yes / No **Liver Disease**
Yes / No **Diabetes**
Yes / No **Migraines**

Yes / No **Nervous Disorder, Depression**
Yes / No **Arthritis**
Yes / No **Anemia**
Yes / No **Thyroid Problems**
Yes / No **Cancer**
Yes / No **Seizures**

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 **Stroke**
Yes / No **High Blood Pressure**
Yes / No **Asthma/Lung Disease**
Yes / No **Cancer** breast[ ] colon[ ] other (specify)[_____]

Yes / No **Thyroid Problems**
Yes / No **Mental Illness**
Yes / No **Migraine Headaches**
Yes / No **Heart** stent[ ] angioplasty[ ] heart attack[ ] other[ ]

Yes / No **Substance Abuse**
Yes / No **Arthritis**
Yes / No **Diabetes (sugar)**
Yes/ No **Substance Abuse problems**

Have you had a colonoscopy? [ ] No [ ] Yes **When?** _____
Smoke [ ] No [ ] Yes Packs per day? _____
Alcohol [ ] No [ ] Yes How much? _____
Exercise [ ] >3 times/week [ ] 1-2 times/week [ ] Rarely
Last Tetanus Shot: _____

Any recreational drug or substance use [ ] No [ ] Yes
What kind? _____

# of Children_____ **Children's ages** _____

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**[ ]