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

Today's Date: _____*2018*

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

Name _____ **Occupation** _____

Sex: Male [ ] Female [ ] **Marital Status:** Married [ ] Single [ ] Divorced [ ] Widowed [ ] 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
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

Have you ever had: (Circle correct answers:)

Yes / No **Problems with eyes**	Yes / No **Stomach Problems**	Yes / No **Nervous Disorder, Depression**
Yes / No **Problems with ears**	Yes / No **Liver Disease**	Yes / No **Arthritis**
Yes / No **Asthma**	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 **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 **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) [_____]		Yes/ No **Substance Abuse problems**

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? _____ **Any recreational drug or substance use** [ ] No [ ] Yes
Exercise [ ] >3 times/week [ ] 1-2 times/week [ ] rarely **What kind?** _____
Last Tetanus Shot: _____

# 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[ ]**