NORTH CAROLINA HEART & VASCULAR
UNC HEALTH CARE

TODAY'S DATE: _____
PHYSICIAN TO SEE: _____

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____Age: _____ Sex _____ Race: _____

Problem to be evaluated _____

Referring Physician _____

PERSONAL INFORMATION

Date of Birth: ___/___/_____ Marital Status: _____

Occupation: _____ Employment Status: ☐ Employed ☐ Retired ☐ Disabled

If disabled, for what reason? _____

How do you learn best? ☐Verbal ☐ Written

What is your preferred language? _____

Do you live alone or with someone? _____

Do you feel safe in your home? ☐ Yes ☐ No

Would you like resource information on abuse or neglect? ☐ Yes ☐ No

PAST MEDICAL HISTORY

* Hospitalizations and surgical procedures (continue on back of page if more space is needed).

	Hospital & City	Reason	Doctor	Year
1.				
2.				
3.				
4				
5.				

* Childhood & Adult Diseases: (Check any of these diseases you have had)

__ Asthma ___ Pneumonia ___ Tuberculosis ___ Diphtheria ___ Kidney failure

__ Bronchitis ___ Emphysema ___ Hepatitis ___ Syphillis

* Habits:

Do you exercise? ____ If yes, how often & for how long? _____

Describe appetite: _____ any weight gain or loss: _____

Amount per day of coffee: _____ tea: _____ soft drinks: _____ alcohol: _____

How much do you smoke (packs per day)? ____ How many years have you smoked? _____

If you do not smoke now, did you ever? ____ How many packs per day? ___ For how many years? ___

MEDICATION LIST (continue on back of page if more space is needed):

Name	**Dosage (mg, etc.)**	**How Often**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

DRUG ALLERGIES / ADVERSE REACTION (what happens when you take it?):

1.
2.
3.
4.
5.

PHARMACY (name, address, phone #)

Local/Retail Pharmacy: _____ Phone # _____

Address _____

Mail Order Pharmacy: _____

FAMILY HISTORY (use back of page if additional space is needed)

	Age	If deceased, age & cause	Any family history of the following? If so, what relation?
Father	____	___ _____	___ Angina/Heart attacks _____
Mother	____	___ _____	___ Heart failure _____
Siblings			___ Diabetes _____
1 M F	____	___ _____	___ High cholesterol _____
2 M F	____	___ _____	___ Rheumatic fever _____
3 M F	____	___ _____	___ Congenital heart disease _____
Children			___ Stroke _____
1 M F	____	___ _____	___ Bleeding disorder _____
2 M F	____	___ _____	___ Blood clots _____
3 M F	____	___ _____	___ Kidney failure _____
			___ Other _____

REVIEW OF SYSTEMS: Please check if you are experiencing any of these symptoms:

General:
___ fever ___ sweats ___ weakness ___ weight change
___ chills ___ fatigue ___ insomnia ___ irritability

Skin:
___ color changes ___ skin eruptions ___ itching ___ scaling ___ easy bruising

Eyes:
___ glasses ___ color blindness ___ blind spots ___ inflammation ___ excessive tearing
___ blurring ___ night blindness ___ double vision ___ discharge ___ sensitivity to light

Ears:
___ pain ___ deafness ___ ringing in ears ___ vertigo ___ itching ___ discharge

Respiratory:
___ cough ___ sputum production ___ wheezing ___ coughing up blood

Gastro-Intestinal:
___ tooth or gum disease ___ belching ___ heart burn ___ abdominal pain ___ mucous in stools
___ difficulty chewing ___ bloating ___ constipation ___ jaundice ___ black/tarry stools
___ difficulty swallowing ___ vomiting ___ diarrhea ___ bloody stools

Genito-Urinary:
___ difficulty urinating ___ painful urination ___ How many times do you have to urinate during the night?
___ incontinence (leaking) ___ kidney stones ___ WOMEN: date of last menstrual period:_____

Endocrine:
___ thyroid disorder ___ goiter ___ feel hot or cold when others are not affected

Neurological:
___ frequent headaches ___ partial/temporary loss of vision ___ numbness/tingling of face
___ severe headaches ___ partial/temporary loss of speech ___ weakness of arms/legs

Musculoskeletal:
___ limitation of movement of joints ___ swelling of joints ___ tenderness of bones or joints

CARDIOVASCULAR HISTORY:

* Do you have a history of any of the following? If yes, explain how long, any treatment, etc:

Diabetes _____
Hypertension _____
High cholesterol _____
Angina _____
Heart Failure _____
Heart murmur _____
Rheumatic fever _____

* Have you have had any of the following tests? If yes, explain when, where, & results if known.

Treadmill test _____
Heart monitor _____
Heart echo (ultrasound) _____
Nuclear heart scan _____
Heart catheterization/angiogram _____

* Symptoms: Please check & describe any of the following symptoms which you have.

☐ Chest pain/tightness/pressure/discomfort? Approximately when did this begin? _____
How would you describe it (sharp, dull, ache, etc.:) _____
Does it radiate to other areas of your body? _____ If yes, where? _____
In what situations do you usually get the discomfort? ☐ Resting ☐ Anxiety/tension ☐ During Sleep
☐ During Exercise ☐ Other _____
How long does it usually last? _____ What helps it go away faster? _____

☐ Shortness of breath? Approximately when did this begin? _____
In what situations do you usually get this symptom? ☐ Resting ☐ Anxiety/tension ☐ Lying down
☐ During Exercise ☐ Other _____
How long does it usually last? _____ What helps it go away faster? _____

☐ Palpitations/fast heart rate? Approximately when did this begin? _____
In what situations do you usually get this symptom? ☐ Resting ☐ Anxiety/tension ☐ During Sleep
☐ During Exercise ☐ Other _____
How long does it usually last? _____ What helps it go away faster? _____

☐ Dizziness? Approximately when did this begin? _____
In what situations do you usually get this symptom? ☐ Resting ☐ Anxiety/tension ☐ Palpitations
☐ During Exercise ☐ Other _____
How long does it usually last? _____ What helps it go away faster? _____
Have you ever lost consciousness during one of these spells? _____

☐ Pain in the calves of the legs/hips. . . Approximately when did this begin? _____
In what situations do you usually get this symptom? ☐ Resting ☐ During Exercise
☐ Other: _____
How long does it usually last? _____ What helps it go away faster? _____

☐ Swelling of the feet/ankles/etc: Approximately when did this begin? _____

NORTH CAROLINA HEART & VASCULAR
UNC HEALTH CARE

North Carolina Heart & Vascular

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. : _____ SS# _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Birth date: _____ Gender: _____ Marital Status: _____ Race: _____

Employer: _____Employer Address: _____

Mother's Maiden Name: _____ Father's Name: _____

Contact Person in Case of Emergency: _____ Phone #:_____

POLICY HOLDER INFORMATION (Other Than Patient)

Last Name: _____ First Name: _____ M.I. : _____ SS# _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Birth date: _____ Sex: _____ Marital Status: _____ Race: _____

Employer: _____Employer Address: _____

Mother's Maiden Name: _____ Father's Name: _____

Contact Person in Case of Emergency: _____ Phone #:_____

RESPONSIBLE PARTY/INFORMATION

Last Name: _____ First Name: _____ M.I. : _____ SS# _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Birth date: _____ Sex: _____ Marital Status: _____ Race: _____

Employer: _____Employer Address: _____

Mother's Maiden Name: _____ Father's Name: _____

Contact Person in Case of Emergency: _____ Phone #:_____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Policyholder's Name: _____

Secondary Insurance: _____ Policyholder's Name: _____

Referring/ Family MD: _____