KERNERSVILLE PRIMARY CARE
420 W. MOUNTAIN ST
KERNERSVILLE, NC 27284

The following information is **confidentia**l. It is used to evaluate your health profile and risk factors.

Name: _____ Date: _____

PRESENT ILLNESSES

Please list health problems which concern you or problems for which you are being treated:

1. _____(NONE) 5._____
2. _____ 6._____
3. _____ 7._____

ALLERGIES

1. _____(NONE) 5._____
2. _____ 6._____
3. _____ 7._____

MEDICATIONS

1. _____(NONE) 5._____
2. _____ 6._____
3. _____ 7._____

PERSONAL HISTORY

Have you ever smoked cigarettes regularly?	Yes	No	How Much? _____
			How Long? _____
Do you presently smoke?	Yes	No	How Much? _____
Do you use alcoholic beverages?	Yes	No	How Much? _____
Do you use seat belts?	Yes	No	How often? _____
Do you use drugs other than medical purposes?	Yes	No	What type? _____
			How often? _____
Have you been a victim of sexual or physical abuse?	Yes	No	Please describe _____
			_____
Are you depressed?	Yes	No	Reason _____
			_____
Have you had your cholesterol checked?	Yes	No	When/Results? _____
			_____

PREVIOUS PHYSICIANS WHOM YOU WOULD LIKE US TO REQUEST YOUR MEDICAL RECORD

_____

Name **Address**

_____

Name **Address**

HEALTH SCREENING QUESTIONS FOR WOMEN

Do you examine your breast for lumps? Yes No

Have you had a pap smear? Yes No Date of last Pap _____

Any history of abnormal Pap? Yes No When? _____

Have you had a mammogram? Yes No When/Results? _____

_____

Please list dates of any pregnancy and outcomes. _____

_____

HEALTH SCREENING QUESTIONS FOR MEN

Do you examine your testicles for lumps? Yes No

Have you had a prostate exam? Yes No

Have you had a PSA test? Yes No When/results?_____

Have you had any trouble achieving or maintaining an erection? Yes No

PAST MEDICAL HISTORY

List all hospitalizations, surgeries and serious medical problems you have had such as high blood pressure, heart disease, elevated cholesterol, diabetes, cancer, hyperthyroid, etc…

1. _____ 5._____

2. _____ 6._____

3. _____ 7._____

IMMUNIZATIONS

Please give date of your last immunization.

Tetanus _____ Hepatitis A _____

Pneumonia _____ Hepatitis B _____

Flu _____ Varicella _____

TB test _____ MMR _____

FAMILY HISTORY

			Who and what age started?
High Blood Pressure	Yes	No	_____
Heart Disease	Yes	No	_____
Diabetes	Yes	No	_____
Kidney Disease	Yes	No	_____
Cancer	Yes	No	_____
Stroke	Yes	No	_____
Suicide	Yes	No	_____
Other inheritable disease	Yes	No	_____
Hearing, Neurological Blood Disorders, etc	Yes	No	_____