Highland Primary Care

513 Lauchwood Drive
Laurinburg, NC 28352
Phone: (910) 506-4510
Fax: (910) 506-4527

9241 Morgan Street
Laurel Hill, NC 28351
Phone: (910) 462-4624
Fax: (910) 462-4627

Health Questionnaire

Name:____ Date:__________________

Age:_______________ Date of Birth: _____________________

What is the purpose of this visit?

Is your health good in general? Yes ______ No ______

What are your major medical problems at present?

Are you being treated by another provider currently?
Who?

What medical conditions have you been treated for?
Please list the condition and date of onset.

1. ________________________________ 5. ________________________________
2. ________________________________ 6. ________________________________
3. ________________________________ 7. ________________________________
4. ________________________________ 8. ________________________________

What surgeries have you had? Approximate Date

1. ____ _____________________
2. ____ _____________________
3. ____ _____________________
4. ____ _____________________

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List any allergic reactions you have had to any medications or foods.

FAMILY HISTORY:
Please list any of your close relatives (parents, grandparents, siblings) who have had the following:

Diabetes (High Sugar) _____
High Blood Pressure _____
Heart Attacks _____
Colon Cancer _____
Breast Cancer _____
Strokes _____

Sickle Cell Disease _____
Sudden Unexplained Death _____
Drug or Alcohol Abuse _____
Osteoporosis _____
Fractured Hip _____
Allergies _____

List any family members who have died and their causes of death if known:

SOCIAL HISTORY:
Are you married, single, divorced, or widowed?

Who lives with you in the home?

Are you employed? If so, where?

What type of work do you or did you do? List any specific hobbies.

Do you have an advance directive (living will, DNR, power of attorney)?

What type of diet are you following?

Regular _______
Vegetarian ______
Vegan ______

Gluten Free ______
Carbohydrate ______
Cardiac _______

Diabetic ________
Keto ________
Specific _______

What is your exercise level?

None _____ Occasional _____ Moderate _____ Heavy _____

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HABITS

Do you wear a seatbelt at all times? Yes _____ No _____
Do you smoke cigarettes? Yes _____ No _____
If yes:
How many packs a day? ________
How many years? _______
Have you ever quit smoking? Yes _____ No _____
Do you smoke a pipe or cigars? Yes _____ No _____
Do you smoke e-cigarettes or vapes? Yes _____ No _____
Do you use smokeless tobacco? Yes _____ No _____
Do you drink alcohol at present? Yes _____ No _____
If yes:
How many drinks per week? ______
What time of the day? ______
What type of alcohol? _________________
If no:
Have you ever drank before? Yes _____ No _____
Do you use any illicit or recreational drugs? Yes _____ No _____
Which illicit or recreational drugs have you used? ____________________________________
Have you ever used intravenous(IV) drugs? Yes _____ No _____
How many years have you used illicit or recreational drugs? ____________
Are you at risk for AIDS? Yes _____ No _____
Do you handle blood or blood products? Yes _____ No _____

DISEASE PREVENTION:

List if you have had the following and when:
Tetanus vaccine ______________________
Pneumonia vaccine ______________________
Flu vaccine ______________________
Hepatitis B vaccine ______________________
HIV test ______________________
Tuberculosis skin test (PPD) ______________________'
Mammogram ______________________
Any abnormal? ______________________
Pap Smear ______________________
Any abnormal? ______________________
Colon Cancer tests ______________________
What type, when, and where? ______________________
Prostate cancer tests ______________________
Cholesterol level ______________________

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PERSONAL HEALTH HISTORY

Check all of the following that you have had in the past or have at this time. If you have a significant health condition that is not shown below, please list it at the bottom.

- ☐ ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disorder
- ☐ Blood Clotting Problem
- ☐ Cancer
- ☐ Eating Disorder
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Anxiety
- ☐ Bipolar Illness
- ☐ Depression
- ☐ Schizophrenia/Psychotic Illness
- ☐ Self-Injury (e.g. cutting, burning)
- ☐ Other Emotional Concern (specify) ____________________
- ☐ Eye Disease (specify) ____________________
- ☐ Gastrointestinal Condition (specify) ____________________
- ☐ Head Injury/Concussion
- ☐ Hearing Impairment
- ☐ Hepatitis B (chronic)
- ☐ Hepatitis C
- ☐ HIV
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Menstrual Disorders
- ☐ Migraine Headaches
- ☐ Mobility Limitations (specify) ____________________
- ☐ Musculoskeletal Problems (specify) ____________________
- ☐ Fractures (specify) ____________________
- ☐ Neurologic Concerns
- ☐ Seizure Disorder
- ☐ Sleep Disorder