

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 pro	oblems at present?	
Are you being treated by anothe Who? What medical conditions have y Please list the condition and dat	ou been treated for?	
1		
2		
3		
4		
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?

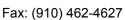
Regular	Gluten Free	Diabetic
Vegetarian	Carbohydrate	Keto
Vegan	Cardiac	Specific

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?		
lf 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