

**CAROLINA SURGICAL CLINIC OF CHARLOTTE, PA
PATIENT QUESTIONNAIRE**

Date _____

GENERAL INFORMATION

Name _____ Referring Physician _____

DOB _____ Age _____ Sex _____ Personal Physician _____

Reason for today's visit _____

PAST MEDICAL HISTORY

a. List any current or past medical conditions (high blood pressure, diabetes, heart problems, etc.) _____

b. List any hospitalizations for other illnesses _____

c. List previous operations and approximate dates _____

ALLERGIES TO MEDICATIONS

Other allergies _____

CURRENT MEDICATIONS

Name of medication	dosage	times per day
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Do you smoke? _____ If yes, how much? _____ packs per day for _____ years.

If you smoked in the past, when did you quit? _____

Do you consume alcohol? _____ If yes, how much and how often? _____

FAMILY HISTORY

	Living (age)	Deceased (age and cause)
Mother	_____	_____
Father	_____	_____
Brothers	_____	_____
Sisters	_____	_____

Do any of the following run in your family: (circle)
Heart disease Diabetes Cancer Bleeding disorder Other diseases _____

SOCIAL HISTORY

Marital status M S D W Number of children _____
Occupation _____

(OVER)

Do you have any of the following?

YES NO

- GENERAL**
- Recent weight change
- Fever
- Excessive fatigue
- EYES**
- Blindness
- Double vision
- Blurry vision
- EARS, NOSE, MOUTH**
- Decreased hearing
- Ringing in ears
- Sores of mouth or tongue
- Difficulty Swallowing
- CARDIOVASCULAR**
- Chest Pain
- Shortness of breath
- Palpitations or skipped heart beats
- Previous heart attack
- Congestive heart failure
- Ankle swelling
- RESPIRATORY**
- Cough
- Asthma
- Emphysema
- GASTROINTESTINAL**
- Nausea or vomiting
- Diarrhea
- Constipation
- Blood in stool
- Hiatal hernia
- Ulcer disease
- Jaundice
- Hepatitis
- GENITOURINARY**
- Kidney stones
- Burning with urination
- Blood in urine
- Incontinence
- Difficulty with urination
- MUSCULOSKELETAL**
- Muscle weakness
- Joint pain
- Arthritis

YES NO

- SKIN**
- Rash
- Boils or sores
- BREAST**
- Mass or lump
- Discharge
- Pain
- NEUROLOGICAL**
- Stroke or paralysis
- Seizures
- Dizziness or fainting
- PSYCHIATRIC**
- Anxiety attacks
- Depression
- Nervous breakdown
- ENDOCRINE**
- Lump or mass in neck
- Thyroid problems
- Other glandular problems
- HEMATOLOGIC**
- Easy bruising or bleeding
- Anemia
- Swollen lymph nodes
- Sickle cell trait
- IMMUNOLOGIC**
- Hay fever
- HIV or AIDS

Do you have any other medical condition

Not covered in this questionnaire?

Explain:

Completed by

Date

CAROLINA SURGICAL CLINIC OF CHARLOTTE, P.A.
Surgical Registration

Account # _____ Date _____

Patient's Full Legal Name _____
Last First Middle Maiden Preferred Name

Patient's Address _____
Street City State Zip Code

Home Phone () _____ Age _____ Birth Date _____ Sex: M F

Cell Phone () _____ Email _____

Patient's Social Security # _____ Married Single Divorced Widowed

Patient's Employer _____
Position Bus. Phone

Spouse / Next of Kin Full Name _____
Last First Middle Maiden

Spouse / Next of Kin Employer _____
Position Bus. Phone

Relative, or close friend, not living with Patient _____
Relationship to Patient Phone

Referring (Doctor) (Person) _____
Name Phone Number

Personal or Family Physician _____
Name Phone Number

Have you ever been a patient in our office before? Yes No When? _____

Were you first seen in the emergency room? _____ Date _____ Doctor _____

Were you hurt at work? _____ Date _____ Contact Person _____

Chief Complaint or Problem _____

Below is for Office Use Only:

First Insurance Company: Medicare Medicaid BlueCross/BlueShield Worker's Comp Copay _____
 Other (Name & Address) _____

Policy # / SS# _____ Group Name / # _____

Subscriber's Name _____ Self Spouse Child Other
Relationship of Patient to Subscriber

Subscriber's Date of Birth _____

Second Insurance Company: Medicare Medicaid BlueCross/BlueShield Worker's Comp Copay _____
 Other (Name & Address) _____

Policy # / SS# _____ Group Name / # _____

Subscriber's Name _____ Self Spouse Child Other
Relationship of Patient to Subscriber

Subscriber's Date of Birth _____