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.
Breast Disease Questionnaire

Name ______________________

Date of birth ______________________

Personal History

Current age __________

Age of first menstrual cycles _________

Age of menopause ________

Last menstrual period _________

Previous breast cancer _________

Previous breast biopsies _________

Hormone therapy use ______________________
Total years _____________
Last taken ____________

Number of pregnancies _________ deliveries _______
Miscarriages/ abortions __________

Your age at first childbirth _________

Did you breast feed? _________ Total months ______

Family History	Relationship	Age at diagnosis
Breast cancer	__________	________
	__________	________
Ovarian cancer	__________	________
Colon cancer	__________	________

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'sComp ☐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'sComp ☐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______________________________