Carolina Infectious Disease PA

1774 Metromedical Drive Fayetteville, NC 28304 Office: (910) 568-3903 Fax: (910) 568-3908

PATIENT HISTORY FORM

Today's date: _____ Date of Birth (mm/dd/yyyy): _____ Chart # _____

Last Name: _____ First Name: _____ MI: _____

Who completed this form? ☐ Patient ☐ Spouse ☐ Other (specify) _____

What is the reason for your visit today? _____

_____

Do you have any current chronic illnesses? ☐ No ☐ Yes, please list: _____

_____

Have you had any prior surgeries? ☐ No ☐ Yes, please list:_____

_____

Are you allergic to any medications? ☐ No ☐ Yes, please list:

Name of Drug	Reaction

Do you currently take any medications daily? ☐ No ☐ Yes, please list: ☐ Attached list

Please list all medications currently taking (prescription and over the counter):

Name of Drug	Dosage	How often taken?	How long on this medication?

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FAMILY HISTORY

Has anyone in your immediate family had any major illnesses, such as heart disease, cancer, diabetes, etc?

☐ No ☐ Yes, please list which family member and illness? _____

_____

SOCIAL HISTORY

- Do you use tobacco? ☐ No ☐ Yes ☐ Former Frequency: _____

Sources: ☐ cigarettes ☐ e-cigs ☐ chewing tobacco

- Do you drink alcohol? ☐ No ☐ Yes ☐ Former Frequency: _____

- Do you use caffeine? ☐ No ☐ Yes ☐ Former Frequency: _____

Sources: ☐ coffee ☐ tea ☐ soda ☐ tablets

- Do you use illicit drugs? ☐ No ☐ Yes ☐ Former Frequency: _____

Sources: ☐ marijuana ☐ heroin ☐ cocaine ☐ pills ☐ Other: _____

- Highest level of education: _____