Name:_____ Date of Birth:_____

Please answer the following questions as completely as possible. The answers will be held in strictest confidence and shared with other healthcare providers (outside of this practice) only with your specific request. If there is something that you do not want shared under any circumstances, please so note. If you need more room for any section please continue on a separate sheet of paper at the end of the questionnaire. Please note Privacy Policies and Procedures at the front desk.

INTENTION FOR CONSULTATION

(What concerns you the most? What is the most function limiting part of your life?)

Allergies to Drugs (Prescription or Non-Prescription) _____

Allergies or Sensitivities to Foods, Pollens, etc._____

MEDICAL STATUS

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications & Duration

Vitamins and Supplements (List as Completely as Possible)

Have you ever had a Mammogram?_____ Date:_____ Results:_____

Do you do breast self exams?_____

Have you ever had a PSA test?_____ Date:_____ Results:_____

Do you do testicle self exams?_____

HOSPITALIZATIONS/OPERATIONS/BROKEN BONES

Dates Operation Physician

Pregnancies (including miscarriages and abortions)
Dates How far along Sex Weight Wks Problems

How did you feel being pregnant?

Any problems with fertility? Please describe:

MEDICAL CONDITIONS

Childhood Diseases: ☐ German Measles ☐ Chicken Pox ☐ Other:
☐ Headaches ☐ Memory Changes ☐ Difficulty in Focus /Concentration ☐ Double Vision
☐ Balance Problem ☐ Asthma ☐ Pneumonia ☐ Recurrent Sinusitis or Bronchitis
☐ Recurrent Lung Infections ☐ Rapid Heat Beat ☐ Skipped Heart Beats ☐ Mitral Valve Prolapse ☐ High Blood Pressure ☐ Stroke ☐ Varicose Veins ☐ Phlebitis ☐ Rheumatic Fever
☐ High Blood Sugar? Symptoms:
☐ Low Blood Sugar? Symptoms:
Length of Time you can go between meals
☐ Thyroid Problems Describe
☐ Indigestion ☐ Heart Burn ☐ Stomach Ulcers ☐ Gallbladder, Pancreas, or Liver Disease ☐ Inflammatory Bowel Disease ☐ Irritable Bowel ☐ Kidney Stones ☐ Urinary Tract Infections ☐ Vaginal Yeast Infections ☐ Psoriasis or Other Skin Conditions
☐ Constipation ☐ Diarrhea Do Stools, in general Sink ☐ or Float ☐
☐ Clotting Defects ☐ Bleeding Tendencies ☐ Blood Transfusions ☐ Anemia ☐ Diabetes
☐ Jaundice/Hepatitis ☐ Epilepsy ☐ Cancer ☐ Arthritis ☐ Gout ☐ Colitis ☐ Chronic Fatigue/Epstein Barr ☐ Eating Disorder ☐ Multiple Sclerosis ☐ Lupus ☐ Sarcoidosis ☐ Fibromyalgia
☐ Panic Attacks? Symptoms?
Usual Time of Occurrence:
How would you describe your energy:

For Expansion on Any of the Topics Above

HABITS

Dietary Preferences/Restrictions

Sample of Days Menu

Breakfast

Lunch

Dinner

Snacks

Routine Physical Exercise Type/How many minutes/How often?

Tobacco Use (How Much?) Previously How Much How Long

Alcohol Use (How Much?) How often:

Caffeine Use (How much?)

Other Substances (How much?) How often:

STRESSES

Family, Work, Self, etc.

FAMILY HISTORY

MEMBER	LIVING?	AGE?	IMPORTANT DISEASES	CAUSE OF DEATH & AGE
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Paternal Aunt(s)				
Maternal Aunt(s)				
Maternal Uncle(s)				
Paternal Uncle(s)				

Gynecological History

Date Last Period Began_____ Date Prior Period Began:_____ Age at first period:_____
Age at Menopause:_____ Problems with Hot Flashes/Night Sweats:_____
Please describe in detail_____

_____

_____

Have you every had an abnormal PAP smear?_____ When?_____
Are you sexually active?_____
Current Birth Control method?_____ How long?_____
Any problems with it?_____
Past Birth Control Methods:_____
Normally (not on pills) the cycle length:_____ Normally the days of flow and the consistency of the flow:_____
Premenstrual Symptoms:_____ Starting When?_____
Describe Symptoms_____
Any current changes in your normal pattern?_____
Any bleeding between periods?_____ When?_____
Any unusual pelvic pain, pressure, or fullness?_____ Describe:_____

_____

Any unusual vaginal discharge or itching:_____ Describe:_____

Sexual History

Any history of sexually transmitted disease?_____
Are there any problems with impotence or changes in libido?_____ Describe:_____

_____

Sleep History

How long does it generally take you to fall asleep?_____
How many hours of uninterrupted sleep do you generally get each night?_____
Do you ever stop breathing?_____
How do you feel when you wake up in the morning?_____
Do you find yourself wanting to take naps during the day?_____
Do you have dreams that you remember on a regular basis?_____

Situational Chance of Dozing

0=No Chance 1=Slight Chance 2=Moderate Chance 3=High Chance of Dozing

Reading_____ Watching TV_____ At a public Event_____ In a meeting_____
Driving_____ Riding 1hr+_____ Sitting and talking_____ Sitting after lunch_____

Current Primary Healthcare Provider or Primary Physician:(Name, Address, Phone/Fax Number)

_____

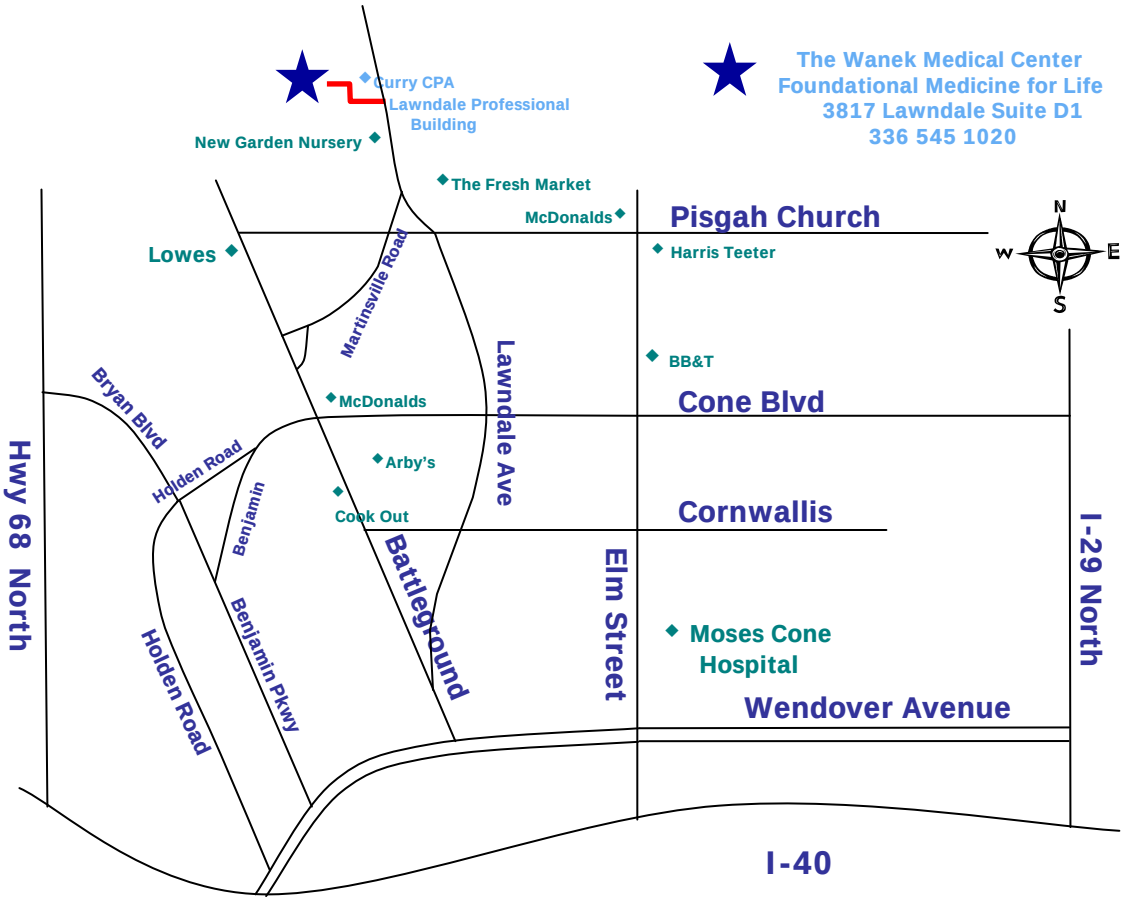
_____

Other Healthcare Providers who Participate in Your Care: (Name, Address, Phone/Fax Number)

_____

_____

_____


Curry CPA
Lawndale Professional Building
The Wanek Medical Center
Foundational Medicine for Life
3817 Lawndale Suite D1
336 545 1020
New Garden Nursery
The Fresh Market
McDonalds
Pisgah Church
Lowes
Harris Teeter
Martinsville Road
Lawndale Ave
BB&T
Bryan Blvd
McDonalds
Cone Blvd
Holden Road
Arby's
Benjamin
Cook Out
Cornwallis
Hwy 68 North
Battleground
Elm Street
I-29 North
Moses Cone Hospital
Holden Road
Benjamin Pkwy
Wendover Avenue
I-40
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W
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