CAROLINA BREAST & ONCOLOGIC SURGERY

2223 Hemby Ln
Greenville, NC 27834
Phone: (252)413-0036
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Health History

Patient Name _____ **Date of Birth** _____

Reason for Visit _____

CURRENT CONDITIONS *Please check all conditions you are currently experiencing.*

General	Cardiovascular	Genitourinary	Neurologic
☐ Recent Illness	☐ Chest Discomfort	☐ Blood in Urine	☐ Blindness
☐ Weight Loss	☐ Ankle/Foot Swelling	☐ Frequent Urination	☐ Fainting
☐ Weight Gain	Shortness of breath (lying flat)	☐ Painful Urination	☐ Seizures
Skin	**Gastrointestinal**	☐ Vaginal Bleeding (unexplained)	**Psychological**
☐ Easy Bruising	☐ Blood in Stool	**Muscle/Joint**	☐ Anxiety
☐ Rash/Hives	☐ Persistent Diarrhea	☐ Muscle/Joint Pain	☐ Depression
☐ Changing Moles	☐ Difficulty Swallowing	☐ Back Pain	Mood Swings
Lung		☐ Trouble Walking	**Endocrine**
☐ Chronic Cough			☐ Heat Intolerance
☐ Waking up with Shortness of Breath			☐ Cold Intolerance
☐ Difficulty Breathing			☐ Excess Thirst

MEDICAL HISTORY *Please check the boxes to indicate if you have had any of these conditions*:

☐ None	☐ COPD/Emphysema	☐ Low Potassium
☐ A-Fib	☐ Depression	☐ Mental Condition
☐ Alcohol Abuse	☐ Diabetes	☐ Migraines
☐ Allergies, Seasonal	☐ Glaucoma	☐ Sleep Apnea
☐ Alzheimer's Disease	☐ Heart Attack	☐ Stomach Ulcer
☐ Anemia	☐ Heart Disease	☐ Stroke
☐ Anxiety Disorder	☐ Hepatitis	☐ Thyroid
☐ Arthritis	☐ High Cholesterol	☐ Vitamin Deficiency
☐ Asthma	☐ High Blood Pressure	☐ Cancer (what type and when) _____
☐ Bleeding Disorder	☐ HIV	_____
☐ Blood Clot	☐ Kidney Disease	

SURGICAL HISTORY *Please use the space below to explain your past surgical procedures with dates.*

_____

_____

Do you or your family have difficulty with anesthesia (malignant hyperthermia) ____ Yes ____ No

PREFERRED PHARMACY_____ **LOCATION & PHONE #**_____

MEDICATIONS/VITAMINS Check the following non-prescription items you use:

☐ Acetaminophin/Tylenol	☐ Ibuprofen (Advil/Motrin)	☐ Supplements
☐ Allergy Pills	☐ Naproxen (Aleve)	☐ Vitamins (Please list)
☐ Aspirin	☐ Natural Hormones	

Please list your prescription medications: _____

ALLERGIES *Please list any allergies or reactions to medication(s):*

FAMILY HISTORY *Please check any condition that exist in your family (include their age when diagnosed).*

☐ Check here if you were adopted.

Condition	Family Member	Age	Condition	Family Member	Age
Heart Disease			Breast Cancer		
High Blood Pressure			Colon Cancer		
Stroke			Ovarian Cancer		
Diabetes			Uterine Cancer		
Arthritis			Other Cancer		
Kidney Stones					

MENSTRUAL HISTORY

Date last menstrual period:	Number of children:
Age at first menstrual cycle:	Age at first live birth:
Birth Control Method:	Contraceptive/HRT: ___Current ___Past

SOCIAL HISTORY

Do you smoke? Yes No	Packs per day:	Years smoking:
Do you drink alcohol? Yes No	Drinks per day:	Per week:

ADVANCE CARE PLAN

Do you have an Advance Care Directive (DNR, Do Not Resuscitate or Living Will)? YES NO

Do you have a Durable Power of Attorney for Health Care or a Health Care Proxy appointed? YES NO

If YES, Who is your Power of Attorney or Health Care Proxy? _____

****If you have a Medical Power of Attorney for the patient listed above, please provide a copy of the documentation.****

The Central Cancer Registry (CCR) collects, processes and analyzes data on all cancer cases diagnosed among North Carolina residents to inform the planning and evaluation of cancer control efforts. All health care providers are required by law to report cases to the CCR, but the primary data source is the hospitals of the state.

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my doctor if I have a change in health.

_____ _____

Signature of Patient, Beneficiary, Guardian or Representative Date

_____ _____

Printed Name of Patient, Beneficiary, Guardian or Representative Relationship to Patient

For CBOS use only: Weight: _____ Intake Staff: _____

BP: _____ Admin Staff: _____