



NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ DOB: \_\_\_\_\_  
 PCP: \_\_\_\_\_ REFERRING PROVIDER: \_\_\_\_\_  
 REASON FOR VISIT: \_\_\_\_\_  
 \_\_\_\_\_

EDUCATION: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 HOBBIES: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

Handedness:  Right Handed  Left Handed  Ambidextrous  
 Would you like to set up your Duke Mychart:  Now  At Home  
 Have you had any recent falls?  Yes  No e-mail: \_\_\_\_\_  
 Is this visit related to worker's compensation?  Yes  No  
 Is this visit related to any legal actions?  Yes  No  
 Is your problem result of an accident?  Yes  No  
 Have you ever been victim of abuse?  Yes  No  
 If yes, to any of the above questions, Please give details \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES:** LIST ANY FOODS OR MEDICATIONS THAT YOU ARE ALLERGIC TO AND INDICATE THE TYPE OF REACTION(S).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS:** PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (ATTACH PAPER IF LONGER LIST)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

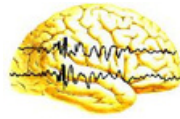
Preferred Pharmacy: \_\_\_\_\_

**PLEASE STOP HERE IF YOU HAVE FILLED OUT THE ONLINE HISTORY QUESTIONNAIRE**

**MEDICAL HISTORY:**

ANEMIA		DEPRESSION		MYOCARDIAL INFARCTION	
ARRHYTHMIA		DEVELOPMENTAL DELAY		MYOPATHY	
ARTHRITIS		DIABETES MELLITUS		NARCOLEPSY	
ASTHMA		GERD		NEUROPATHY	
ATRIAL FIBRILLATION		GLAUCOMA		OSTEOPOROSIS	
BRAIN CANCER		HIV/AIDS		PARKINSON'S DISEASE	
CANCER		HYDROCEPHALUS		SARCOIDOSIS	
CEREBRAL HEMORRHAGE		HYPERLIPIDEMIA		SEIZURES	
CHF		HYPERTENSION		SLEEP APNEA	
CLOTTING DISORDER		KIDNEY DISEASE		STROKE	
COPD		MIGRAINE		THYROID DISEASE	
DEMENTIA		MULTIPLE SCLEROSIS		TREMOR	

Other Medical History: \_\_\_\_\_



**SURGICAL HISTORY:**

BIOPSY MUSCLE		CORONARY ANGIO W STENT		SPINE SURGERY	
BLEPHAROPLASTY		CRANIOTOMY		STRABISMUS SURGERY	
CABG		JOINT REPLACEMENT		SUBDURAL HEMATOMA	
CAROTID ENDARTERECTOMY		NEUROSTIMULATOR IMPLANT		THYMECTOMY	
CAROTID STENT		OVARY REMOVAL		VALVE REPLACEMENT	
CARPAL TUNNEL RELEASE		PACEMAKER		VP SHUNT	

Other Surgical History: \_\_\_\_\_

**FAMILY HISTORY:**

RELATIONSHIP	NO KNOWN PROBLEM	ALZHEIMER'S DISEASE	ALS	ANEURYSM	BRAIN HEMORRHAGE	BRAIN CANCER	CANCER	CHARCOT-MARIE-TOOTH	CLOTTING DISORDER	CORONARY ARTERY DISEASE	DEEP VEIN THROMBOSIS	DEMENTIA	DEVELOPMENTAL DELAY	DIABETES MELLITUS	DYSTONIA	HEART ATTACK	HYPERLIPIDEMIA	HYPERTENSION	KIDNEY DISEASE	LIVER DISEASE	MENTAL RETARDATION	MIGRAINES	MULTIPLE SCLEROSIS	MYASTHENIA GRAVIS	STROKE	TREMOR
MOTHER																										
FATHER																										
SISTER																										
BROTHER																										
DAUGHTER																										
SON																										
MGM																										
MGF																										
PGM																										
PGF																										

Other Family History: \_\_\_\_\_

**SOCIAL HISTORY:**

ALCOHOL USE:  YES  NO  DEFER

IF YES, INDICATE AMOUNT PER WEEK

GLASSES OF WINE	CANS OF BEER	SHOTS OF LIQUOR	DRINKS WITH 0.5 OZ OF ALCOHOL
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SEXUALLY ACTIVE:  YES  NO  NOT CURRENTLY  DEFER

SUBSTANCE USE:  YES  NO  DEFER

TOBACCO USE:  NEVER SMOKER  FORMER SMOKER  CURRENT EVERY DAY SMOKER  SMOKELESS TOBACCO  
 \_\_\_\_\_ PACKS PER DAY \_\_\_\_\_ YEARS  E-Cigarette / VAPING

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**NURSE USE: VITALS**

BP: / , PULSE: , TEMP: , SPO2 , WEIGHT , HEIGHT . PAIN /10.