**Carolina Cardiology, Sleep & Obesity Center, PC**

**Primary Care**

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**New Patient Questionnaire- Primary Care**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Health History**

**Immunizations** (include approx. year):

Tetanus\_\_\_\_\_\_\_ Pneumonia/Pneumovax\_\_\_\_\_\_\_ Hepatitis A\_\_\_\_\_\_\_ Hepatitis B\_\_\_\_\_\_\_

Influenza (Flu)\_\_\_\_\_\_\_ Prevnar 13\_\_\_\_\_\_\_ Gardasil (HPV)\_\_\_\_\_\_\_ Shingles Vaccine/Zostavax\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY: Have you ever had any of the following problems?**

( ) ALCOHOL/DRUG PROBLEM ( ) ANXIETY

( ) ARTHRITS ( ) ANEMIA

( ) ASTHSMA ( ) ATRIAL FIBRILLATION

( ) DEMENTIA ( ) DIABETES

( ) CANCER-TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) EMPHYSEMA/COPD

( ) HEART ATTACK ( ) HEART-CORONARY ARTERY DISEASE

( ) HEART-HEART FAILURE/CHF ( ) HIGH BLOOD PRESSURE

( ) HIGH CHOLESTEROL ( ) HYPOTHYROIDISM (LOW)

( ) HYPERTHYROIDISM (HIGH) ( ) KIDNEY DISEASE

( ) LIVER DISEASE ( ) OSTEOPOROSIS

( ) PROSTATE PROBLEM ( ) PSYCHIATRIC- DEPRESSION

( ) PSYCHIATRIC DISORDER-OTHER ( ) SEIZURE DISORDER

( ) STROKE ( ) ULCERS OF THE STOMACH

( ) STD/SEXUAL INFECTION ( ) ABNORMAL PAP TEST

( ) BLOOD CLOTS ( ) PERIPHERAL ATERY DISEASE

( ) NEUROPATHY ( ) SLEEP APNEA

( ) HEART MURMUR ( ) MIGRAINES

( ) HEPATITIS ( ) DIVERTICULOSIS

( ) COLON POLYPS ( ) POSITIVE TB TEST

OTHER PROBLEMS NOT LISTED ABOVE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History (Women only):** Pregnancies: Number\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Natural or C-Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mentrual Periods: Age Onset\_\_\_\_\_ Average length\_\_\_\_\_\_\_\_ Regular: Yes No if No, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last period:\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain associated w/period: Yes No Date of last pelvic exam/Pap Smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy: No If Yes, why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Control Pills: No Yes, type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone Replacement Therapy: No if Yes, type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*OPERATIONS/PREVIOUS SURGERIES\*\*\*\*\***

( ) Appendectomy ( ) Cardiac Bypass ( ) Cardiac Angioplasty ( ) Gallbladder Laparoscopic ( ) Gallbladder Open ( ) Tonsillectomy ( ) Hernia Repair ( ) Prostate Surgery ( ) Vasectomy ( ) Cataract Surgery: Left Right ( ) C-Section (Cesarean)

( ) Hysterctomy- Partial or Total ( ) Tubal Ligation ( ) Breast Surgery: Left Right

 Orthopaedic Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening Tests** Aprrox Date: Aprrox Date:

Cholesterol Test **\_\_\_\_\_\_\_\_** \_\_Normal \_\_AbnormalPap Smear **\_\_\_\_\_\_\_\_** \_\_Normal \_\_Abnormal

Colonoscopy **\_\_\_\_\_\_\_\_** Mammogram **\_\_\_\_\_\_\_\_** \_\_Normal \_\_Abnormal

Prostate Test **\_\_\_\_\_\_\_\_** Bone Density Test **\_\_\_\_\_\_\_\_** \_\_Normal \_\_Abnormal

Dental Exam **\_\_\_\_\_\_\_\_**

Eye Exam **\_\_\_\_\_\_\_\_** \_\_Normal \_\_Abnormal \_\_Glasses \_\_Contacts \_\_Cataracts

**MEDICATIONS: Please include over the counter and vitamins and please include strength and dosing instructions**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*\*FAMILY HISTORY\*\*\*\*\***

( ) HIGH BLOOD PRESSURE ( ) DIABETES ( ) HEART DISEASE ( ) HEART FAILURE

( ) ANGINA ( ) HEART ATTACK ( ) HIGH CHOLESTEROL ( ) CARDIOMYOPATHY

( ) STROKE ( ) ATRIAL FIBRILLATION

**ALLERGIES: Please list any Drug Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food or Environmental Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

**TOBACCO HISTORY:**

( ) CURRENT SMOKER ( ) FORMER SMOKER ( ) NEVER A SMOKER

\_\_\_\_\_ PACKS PER DAY QUIT HOW LONG AGO? \_\_\_\_\_\_

**ALCOHOL HISTORY:**

( )ALOCHOLIC ( ) OCCASIONAL DRINKER ( ) SOCIAL DRINKER ( ) NEVER DRINK

**ILLICIT DRUG USE:**

( ) YES IF YES, WHAT TYPE/ HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) NO

**EXERCISE:** HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHAT TYPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual Health:** Sexually Acitve Not currently Sexually Active Never sexually Active # of partners in the past year\_\_\_\_\_\_\_

History of Sexually Transmitted Infection? No If Yes, type and when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contraception Method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Functional Health:** (check one) \_\_Independent \_\_Partially Dependent \_\_Fully Dependent

**Mental Health:**

( ) Anxiety ( ) Binge eating Disorder ( ) Depression ( ) Panic attacks

( ) Alcoholism ( ) Bipolar Disorder ( ) Drug addiction ( ) Schizophrenia

( ) Anorexia ( ) Bulimia ( ) Night eating disorder ( ) Stress

**Exercise Habits:**

**Inactive Light Activity Moderate Activity Heavy Activity Vigorous Activity**

No regular no organized activity occasional, weekend consistent physical activity extensive exercise 60+min 4x week

Type of Activity, How Long and How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**System Review**

**Check the box if you are currently experiencing any of the following:**

**General:**

□ Weight loss or gain

□ Fatigue

□ Fever or chills

□ Weakness

**Skin:**

□ Rashes

□ Color changes

□ Hair and nail changes

**Head:**

□ Headache □ Head injury

**Eyes/Ears/Nose/Throat:**

□ Vision changes

□ Decreased hearing

□ Ear pain

□ Ringing in ears

□ Nasal congestion

□ Nose bleeds

□ Hoarse voice

□ Sore throat

□ Sneezing

□ Sinus problems

□ Lump in neck

**Breasts:**

□ Lumps

□ Pain

□ Discharge

□ Rash

**Respiratory:**

□ Wheezing

□ Difficulty breathing

□ Night sweats

□ Shortness of breath

□ Bloody sputum

□ Productive cough

□ Dry cough

**Cardiovascular:**

□ Chest pain or discomfort

□ Tightness

□ Palpitations

□ Shortness of breath with

activity (dyspnea)

□ Difficulty breathing

lying down (orthopnea)

□ Swelling (edema)

□ Sudden awakening from

sleep with shortness of

breath (Paroxysmal

Nocturnal Dyspnea)

**Gastrointestinal:**

□ Swallowing difficulties

□ Heartburn

□ Change in appetite

□ Nausea

□ Change in bowel habits

□ Rectal bleeding

□ Constipation

□ Diarrhea

**Urinary:**

□ Frequency

□ Urgency

□ Burning or pain

□ Blood in urine

(hematuria)

□ Incontinence

□ Change in urinary

Strength

**Men:**

□ Pain with sex

□ Hernia

□ Penile discharge

□ Sores

□ Masses or pain

□ Erectile dysfunction

□ STD’s

**Women:**

□ Pain with sex

□ Vaginal dryness

□ Hot flashes

□ Vaginal discharge

□ Itching or rash

□ STD’s

**Vascular:**

□ Calf pain with walking

(Claudication)

□ Leg cramping

**Musculoskeletal:**

□ Muscle or joint pain

□ Stiffness

□ Back pain

□ Redness of joints

□ Swelling of joints

□ Trauma

**Neurologic:**

□ Dizziness

□ Fainting

□ Seizures

□ Weakness

□ Numbness

□ Tingling

□ Tremor

**Hematologic:**

□ Ease of bruising

□ Prolonged bleeding

**Endocrine:**

□ Head or cold intolerance

□ Sweating

□ Frequent urination

(polyuria)

□ Thirst (polydypsia)

□ Change in appetite

(polyphagia)

**Psychiatric:**

□ Nervousness

□ Depression

□ Memory loss

□ Stress

□ Anxiety