2223 Hemby Lane
Greenville, NC 27834
Phone: (252) 413-0036
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CAROLINA BREAST AND ONCOLOGIC SURGERY

MRN:_____

HEALTH HISTORY UPDATE

All information is strictly confidential

Date:_____

Name:	Date of Birth:
Best # to Reach You:	Additional Phone #'s:
Address:	Email Address:
City: State: Zip:	Employer:
Marital Status:	Emergency Contact Name:
Referring Provider:	Emergency Contact Relationship:
Primary Care Physician:	Emergency Contact Phone #:
Pharmacy Name/Location:	

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONNAIRE

(Please check SYMPTOMS you CURRENTLY have)

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

(Please check MEDICAL CONDITIONS you HAVE currently or HAD in the past)

□ Heart Disease □ Heart Attack □ Stroke □ High Blood Pressure □ High Cholesterol	□ Diabetes □ COPD/Emphysema □ Asthma □ Sleep Apnea □ Goiter	□ Anemia □ Bleeding Disorder □ Hepatitis A, B or C □ HIV/AIDS □ Arthritis	□ Migraines □ Stomach Ulcers □ Glaucoma □ Psychiatric Problem □ Anxiety Disorder	□ Depression □ Kidney Disease

Please list any NEW MEDICAL CONDITIONS or SURGERY since your last visit with us:_____

_____

Current Medications: *(Please list ALL medications, vitamins, and/or supplements you are currently taking.)*

Medication(s):

Do you have any allergies? **YES** **NO**

(If yes, please list below.)

Allergic to:

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.

Patient Signature: _____ **Date:** _____