UNC REX HEALTHCARE

Patient Information Questionnaire

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____ Email:_____

City:_____ State:_____ Zip:_____ Social Security #:_____

Home Phone: (____)_____ Cell Phone: (____)_____ Date of Birth:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Self-Employed ☐ Unemployed ☐ Other:_____

Occupation: _____ Email: _____

Decision Maker in the Event of Emergency: _____ Relationship:_____

Decision Maker's Phone: (____)_____

Pharmacy:_____ Pharmacy Phone #: (____)_____

PHYSICIAN INFORMATION

Primary Care Practice Name:_____ Physicians Name:_____

Primary Care Phy. Address:_____ State:_____ Zip:_____ Phone:(____)_____

REASON FOR VISIT

What is the reason for your visit: ☐ Annual Exam ☐ Obstetric first visit ☐ GYN problem

If you are here for a problem what are your concerns? _____

_____

_____

HEALTH MAINTENANCE / PREVENTIVE SCREENING

Colonoscopy	☐ Yes ☐ No	If yes; date / /	Results:	☐ Normal	☐ Abnormal
Dexa Scan	☐ Yes ☐ No	If yes; date / /	Results:	☐ Normal	☐ Abnormal
Mammogram	☐ Yes ☐ No	If yes; date / /	Results:	☐ Normal	☐ Abnormal

PAP SMEAR

Pap smear	☐ Yes ☐ No	If yes; date / /	Results:	☐ Normal	☐ Abnormal
LEEP	☐ Yes ☐ No	If yes; date / /	Results:	☐ Normal	☐ Abnormal
History of HPV?	☐ Yes ☐ No	If yes; date / /			
Received HPV vaccine?	☐ Yes ☐ No	If yes; date / /	☐ Inj. 1	☐ Inj. 2	☐ Inj. 3

PAST SURGICAL HISTORY *(within past 5 years)*

Year	Surgery	Complications?

MEDICAL HISTORY ***(Place check mark beside all that apply)***

Condition	Yes	Condition	Yes	Condition	*Yes*	Condition	Yes
Anemia		Chronic Lung Disease		High Blood Pressure		Osteopenia	
Anxiety		Depression		High Cholesterol		Osteoporosis	
Arthritis / Joint Pain		Diabetes Type 1		Hypothyroid		Ovarian Cancer	
Asthma		Diabetes Type 2		Hyperthroid		Seizures	
Blood Clot / DVT		Fibroids		Interstitial Cystitis		STD	
Blood Transfusions		GERD		Irritable Bowel Syndrome		Stroke	
Breast Cancer		Heart Disease		Jaundice		Tuberculosis - TB	
Cancer		Hepatitis ☐ A ☐ B ☐ C		Migraines			

MEDICATIONS ***(Please include prescription, non-prescription, vitamins, birth control pills, and herbs, with dosages)***
If there is not sufficent space please attach copy of medication list to this form.

Medication	Dosage (mg)	Frequency	Medication	Dosage (mg)	Frequency

ALLERGIES ***(Food, Drugs, Environmental)*** ☐ None ☐ Latex ☐ Iodine

Allergy	Interaction	Allergy	Interaction

FAMILY HISTORY **Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column.**

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots / DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											

GENETIC SCREENING ☐ None (Includes patient, baby's father, or anyone in either family)

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Maternal Metabolic Disorder		
Neural Tube Defect			Mental Retardation / Autism		
Sickle Cell Disease or Trait			Medication / Street Drugs/ Alcohol		
Thalassemia			Muscular Dystrophy		
Hemophilia			Huntington Chorea		
Cystic Fibrosis			Recurrent pregancy loss or a still birth		
Down Syndrome			Other inherited genetics or chromosomal disorder		
Congenital Heart Defect			Patient or father of the baby had/has a child with birth defects not listed		

GYNECOLOGY

Age at first period:	Do you have concerns regarding you period? Describe:
Frequency of period:	
Length of period:	
1st day (date) of last period:	Are you in menopause? ☐ Yes ☐ No ☐ Unsure
Describe Period: ☐ Light ☐ Normal ☐ Heavy	Date of last period:
Current Contraceptive Method:	Are you on hormone replacement therapy? ☐ Yes ☐ No

OBSTETRICS

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	# Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications
1						
2						
3						
4						
5						
6						

SOCIAL HISTORY

Are you curently sexually active? ☐ Yes ☐ No If **Yes**, what age did you become sexually active? _____
Current Sexual partner(s) is/are: ☐ Male ☐ Female ☐ Male and Female
Have you ever had any sexually transmitted diseases? (STD's): ☐ Yes ☐ No
If **Yes**, what kind? _____
Are you interested in STD screening? ☐ Yes ☐ No
Do you use tobacco products? ☐ Yes ☐ No If **Yes**, packs per day?_____ Number of years? _____
If **No**, have you ever? _____ When did you Quit? _____
Do you use smokeless tobacco? ☐ Yes ☐ No If **Yes**, packs per day?_____ Number of years? _____
If **No**, have you ever? _____ When did you Quit? _____
Do you drink alcohol? ☐ Yes ☐ No If **Yes**, how many drinks per week?_____Wine _____Beer _____Liquor
Do you use recreational drugs? ☐ Yes ☐ No If **Yes**, use per week?_____ Type: _____

LIFE STYLE

Do you exercise? ☐ Yes ☐ No If **Yes**, how often? _____ Type: _____
Do you live alone? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Have you been a victim of abuse or domestic violence? ☐ Yes ☐ No
Do you perform self-breast exam? ☐ Yes ☐ No

Blood Transfusion / Products	**Yes**	**No**	**If No, Please briefly explain why.**
Would you accept a blood transfusion or blood products in the event of a life threatening situation?			

AUTHORIZATION AND RELEASE

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

_____ _____
(Patient or Legal Guardian) Signature Date