CARROLL HEALTH GROUP
A LifeBridge Health Partner

Name:_____**DOB:**_____

Address: _____ **Phone #**_____

Primary Care Physician: _____ **Pharmacy:** _____

Reason for visit: _____ **Work Related**: Yes or No

Duration of symptoms: _____**Occupation**: _____

Medication Allergies: ☐ Latex ☐ Tape ☐ Betadine ☐ Iodine ☐ Contrast/IV dye ☐ None

☐ Other: _____

Current medications (include dosage & frequency):

_____

_____

_____

_____

Past or present medical problems (Check any that apply) ☐ Diabetes ☐ Hypertension ☐ Cancer

☐ Stroke ☐ Bleeding tendency ☐ MRSA ☐ Arthritis/Gout ☐ C. Diff ☐ Acute Infections

☐ Cardiovascular ☐ Pulmonary/Respiratory ☐ Other _____

Past surgeries: ☐ Colonoscopy ☐ EGD ☐ Appendectomy ☐ Hernia surgery ☐ Gallbladder removal

Other: _____

Family History: (Diabetes, cardiac issues, cancers; if so, which type)

Father: _____

Mother: _____

Brothers:_____ Sisters: _____

Maternal grandmother: _____ Maternal grandfather: _____

Paternal grandmother: _____ Paternal grandfather: _____

Social History:

Tobacco use: ☐ Abstains ☐ Former smoker ☐ Current smoker

Alcohol use: ☐ Abstains ☐ Rarely ☐ Social drinker ☐ Daily use ☐ Recovering alcoholic

Illicit drug use: ☐ Abstains ☐ Former/recovering ☐ Current; type/how often: _____

CARROLL HEALTH GROUP
A LifeBridge Health Partner

Name: _____ DOB: _____

Please **circle** all that apply or check the box for "none":

Allergic/immunologic	☐ None	Itching, sneezing, watery eyes, recurrent infections
Cardiovascular	☐ None	Chest pain, palpitations, heart disease, swelling of feet, ankles, hands
Constitutional	☐ None	Fevers, chills, unexplained weight change, fatigue
Ears	☐ None	Hearing loss, ear infections, ear pain
Endocrine	☐ None	Hormone/glandular issues, thyroid disease, diabetes, excessive thirst or urination, heat or cold intolerance
Eyes	☐ None	Eye disease or injury, visual changes, eye pain, wear glasses or contacts
Gastrointestinal	☐ None	Diarrhea, constipation, blood in stools, abdominal pain, vomiting, heartburn, loss of appetite, peptic ulcer
Genitourinary	☐ None	Frequent/painful urination, blood in urine, incontinence/dribbling, testicle pain, kidney stones
Hematologic/lymphatic	☐ None	Easy bruising, easy bleeding, swollen glands, slow to heal from wounds, anemia
Musculoskeletal	☐ None	Joint pain, muscle pain, joint swelling, weakness, difficulty walking
Neurological	☐ None	Headaches, dizziness, burning/tingling sensations, confusion, slurred speech, stroke, head injury, seizures
Nose/mouth/throat	☐ None	Nasal congestion, runny nose, oral lesions, postnasal drip, sore throat
Psychiatric	☐ None	Anxiety, depression, memory loss, confusion
Respiratory	☐ None	Asthma, cough, shortness of breath, wheezing
Skin/integumentary	☐ None	Rash, bothersome skin lesions, change in skin color, breast pain or discharge

Patient signature: _____ **Date:** _____

Providers signature: _____ **Date:** _____