MEDICAL HISTORY WORKSHEET **Cary Medical Group**

Name:_____ **DOB:**____/____/____**Chart #:**_____

Personal Data:

Marital status: Single Married Divorced Widowed

Occupation (if applicable):_____ Education: _____

Tobacco Product Use: (circle one) None/ Current use/Past Use Type of product:_____
How much per day? _____ How long? _____

Daily caffeine consumption: Y N How much per day? _____

Alcohol use: Y N How much per: day_____ week_____ month_____

Do you use any other types of drugs other than over-the-counter, supplements and/or prescription medications? Y N If yes, what do you use and how often? _____
_____

Exercise Regimen: How often?_____ What type?_____

Do you wear your seat belt on a regular basis? Y N

Medication allergies: Please list any medication allergies and type of reaction:

Name of Medication	Reaction

Do you have any other allergies? (i.e. foods, dyes, environmental, bee stings, etc)
_____

Medications (Prescription/Over-the-Counter/Supplements)

Name of medication	Dosage	Daily directions

Current Medical Problems	**Date of Onset**

Past Medical Problems/Hospitalizations/Surgeries	**Date**

Females: # of pregnancies_____# of live births_____ Type of delivery:_____

Family Medical History: Please list all relatives diagnosed with any of the following conditions including their age at onset (please note if deceased).

Heart disease:_____
Diabetes: _____
Cancer/Type: _____
Hypertension: _____
Mental Health/Depression: _____
Other: _____

Screenings (date of last):
Mammogram:_____
Pap Smear:_____
Colonoscopy:_____
Bone Density:_____
PSA:_____

Immunizations (date received):
Tetanus:_____
Pneumovax:_____
Influenza:_____
Hepatitis A/B:_____
PPD (TB Skin Test):_____
Zostavax:_____
Tdap:_____

Do you have a living will? Y N **Advanced Directive?** Y N

Other specialists that you see on a regular basis: (Name and specialty)

_____
_____
_____