

# NORTH CHARLOTTE FAMILY MEDICINE, PLLC

2801 Crisman St.  
Charlotte, NC 28208  
(704) 392-4108-office / (704) 392-4109-fax

## MEDICAL HISTORY

COMPLETE NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_ SEX M F MARITAL STATUS M S W D SEP

### PAST/CURRENT MEDICAL HISTORY (check box for any "yes" answers)

Recurrent ear infections	Psychiatric consultation/ Treatment/hospitalization	Venereal disease
Headaches	Suicide attempt	Bone, Joint, back disorder or injury
Dizziness or fainting spells	Excessive bleeding after surgery or dental work	Hearing aid/pacemaker/artificial limb/other physical apparatus
Paralysis/numbness/tingling	Asthma	Motion limitation: physical disability
Epilepsy-fits, seizures (convulsions)	Pneumonia	Malaria
Eye disease-glaucoma, etc.	Chronic cough	Tuberculosis or Positive TB Test
Wears corrective lenses	Lung disease	Chronic or frequent colds
Eye surgery to correct vision	Frequent indigestion	Skin disease or skin problem
Lack of vision in either eye	Stomach, liver intestinal problems	Diabetes
Chest pain	Hepatitis or yellow jaundice	High cholesterol
Heart Trouble	Kidney disease	Anemia, Blood problems
High blood pressure	Bladder disease	Cancer
Shortness of breath	Hernia or rupture	Benign Tumor
Rheumatic Fever		

Have any of your relatives had, or do they now have:

Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ Headaches \_\_\_\_\_ Epilepsy \_\_\_\_\_ Mental Illness \_\_\_\_\_

Heart Trouble \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stroke \_\_\_\_\_ Other \_\_\_\_\_

What relatives have the above illnesses?

Have you ever been under observation, had medical, psychiatric, or surgical advice or treatment, or have been hospital-confined? **If so, please provide name of condition, duration (specify dates), and final results.**

Do you have a primary physician? Please provide your physician's name and telephone number:

\_\_\_\_\_

## MEDICAL HISTORY

What is your occupation? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Are you being treated for any condition now? \_\_\_\_\_

Have you had any accidents as a result of which you are partially disabled? \_\_\_\_\_

If so, what and when? \_\_\_\_\_

Do you have any other disability? \_\_\_\_\_

Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst in the last 5 years? \_\_\_\_\_

If so, please give his/her name and telephone number: \_\_\_\_\_

For what reason? \_\_\_\_\_ Date of consultation \_\_\_\_\_

Are you taking any medicine regularly? \_\_\_\_ If so, what? \_\_\_\_\_

Do you have any allergies? \_\_\_\_ If so, which? \_\_\_\_\_

Have you gained or lost weight during the last three years? \_\_\_\_ If so, how much? \_\_\_\_\_

Have you ever stayed in a tropical country? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

Do you smoke? \_\_\_\_ If so, what do you smoke? Cigarettes \_\_\_\_ Pipe \_\_\_\_ Cigars \_\_\_\_ Other \_\_\_\_\_

For how many years have you smoked? \_\_\_\_\_ How much per day? \_\_\_\_\_

Daily consumption of alcoholic beverages: \_\_\_\_\_

Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future?

If so, give details \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_

**FOR WOMEN** Have you ever been treated for a gynecological complaint? \_\_\_\_ YES \_\_\_\_ NO

If so which and when? \_\_\_\_\_

Any irregular menstrual cycles? \_\_\_\_\_ How often? \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of living children? \_\_\_\_\_

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## PHYSICAL EXAMINATION\*

TO BE COMPLETED AND SIGNED BY PHYSICIAN

NAME OF PATIENT \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Respirations** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Temperature** \_\_\_\_\_  
 \_\_\_\_\_ inches/meters \_\_\_\_\_ pounds/kilograms

**Check each item: N - Normal**  
**AN: - Abnormal (describe)**  
**O: - Not examined**

Note to physician: Describe abnormalities below. Use reverse side if necessary. Describe significant injuries or illnesses since date of last examination. Specify especially any disability or other sequela. Please review applicant's self-administered Medical History form.

	N	AN	O	Description of Abnormality
Eyes/Vision				
Ears/Hearing				
Head/Nose/Sinuses				
Mouth/Throat/Pharynx				
Neck/Thyroid				
Chest/Breasts				
Blood Pressure				
Heart/murmurs/rhythm				
Lungs				
Peripheral Vessels				
Abdomen				
a) Liver				
b) Spleen				
c) Other				
Groin Genitalia (Hernia?)				
Back				
Rectum-Anus				

Prostate				
Lower Extremities				
Joints				
Neurologic				
a) Sensory				
b) Motor				
c) DTR's				
Skin				
Lymph Nodes				

**Has the applicant ever suffered from any nervous or mental disorders?** If so, please provide name of condition, duration (specify dates), and final results.

After reviewing the applicant's medical history (pages 1 and 2 of this form) and completing the physical examination, do you consider the applicant to be physically and mentally capable of successfully pursuing and completing a full-time program of study in an academic institution and of adjusting to living overseas? If your answer is NO, please comment reasons why.

How would you rate the applicant's health, mental, and physical condition?

Excellent                           Good                      Fair                      Poor

**Tests and Results**

BCG vaccine \_\_\_\_\_

PPD Skin Test \_\_\_\_\_

Chest X-Ray if positive + PPD \_\_\_\_\_

EKG (Over 40) \_\_\_\_\_

Occult Blood Test (Stool) (over 50) \_\_\_\_\_

Or family history colon cancer \_\_\_\_\_

**SUMMARY:**

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Physician's Signature