UNC HOSPITALS

Place Sticker Here

Referring Provider: ______________________________________

Reason for Visit: ____

Please check all of the following that apply to you.

General Symptoms
___Weight Loss/Gain
___Snoring
___Night Sweats
___Fatigue
___Difficulty Sleeping
___Recent Fever or Chills
___Daytime Drowsiness

Cardiovascular Symptoms
___Chest Pain
___Irregular Heartbeat
___Fainting
___Heart Palpitations
___Shortness of Breath with exertion
___Difficulty breathing when flat
___Swelling of ankles/legs

G.I Symptoms
___Bloody or black stool
___Nausea
___Vomiting
___Stomach Pain
___Diarrhea
___Constipation
___Heartburn

Skin Symptoms
___Rash
___Ulcers/sores
___Skin changes
___Hives
___Redness
___Yellow/Jaundice
___Itching/Dryness

Endocrine Symptoms
___Increased Sweating
___Excess Thirst
___Hot flashes
___Excess Urination
___Changes in hair or skin texture
___Thinning hair
___Intolerance to heat or cold
___Decreased sex drive
___Decreased sexual performance

Musculoskeletal Symptoms
___Joint aches/swelling
___Spasms/Spasticity/cramps
___Muscle aches/weakness
___Muscle wasting

Neurological Symptoms
___Dizziness/vertigo
___Tremors
___Fainting
___Excessive Sleeping
___Coordination difficulty
___Headaches/Migraines
___Seizures
___Numbness/Tingling

Psychiatric Symptoms
___Depression
___Anxiety
___Low energy
___Panic attacks
___ Agitation
___ Anger
___Memory loss
___Lack of interest in activities
___Feelings of hopelessness
___Isolating yourself

Urological Symptoms
___Loss of bladder control
___Difficulty urinating

Hematological Symptoms
___Easy bleeding
___Easy bruising

<u>Medical History:</u>

Please check all of the following that apply to you.

___ Abnormal ECG
___ Alcoholism
___ Anemia
___ Aneursym
___ Arthritis
___ Asthma
___ Cancer
___ Carotid disease
___ Congestive Heart Failure
___ Cirrhosis
___ Blood clotting disorder
___ Concussion
___ Ulcers (GI)

___ COPD (Emphysema)
___ Coronary artery disease
___ Deep vein thrombosis
___ Depression
___ Diabetes mellitus
___ Emphysema
___ Gall Bladder Disease
___ Headaches
___ Hepatitis
___ History of blood transfusion
___ HIV/AIDS
___ Hyperlipidemia
Other: ______________________

___ Hypertension (High blood pressure)
___ Kidney disease
___ Liver disease
___ Neuropathy - peripheral
___ Pneumonia
___ Pulmonary arterial hypertension
___ Seizures
___ Sickle cell anemia
___ Stroke
___ Drug Abuse Disorder
___ Thyroid disease
___ TIA

Surgical History:

Please check all of the following that apply to you.

___ Abdomen surgery
___ Aneursym repair
___ Bladder suspension
___ Brain surgery
___ Cerebral angiogram
___ Colon surgery
___ Colonoscopy
___ Coronary stent placement
___ Craniotomy
___ Gastric fundoplication
___ Hip surgery
___ Hysterectomy
___ Knee surgery
___ Lung surgery
___ Pituitary surgery
___ Shoulder arthroscopy
___ Spinal fusion
___ Spine stimulator
___ Spine surgery
___ Weight loss surgery
___ VP shunt

Other: ____

Family History:

Please check all of the following that apply to your family members. Please indicate if they are alive or deceased.

Relationship	Status	Asthma	Anesthesia Problems	Ataxia	Bleeding Disorder	Blood clots (DVT)	Cancer	COPD	Dementia	Diabetes	Emphysema	Heart Disease	Hypertension	Migraines	Multiple Sclerosis	Neurofibromatosis	Neuropathy	Osteoporosis	Parkinsonism	Seizures	Stroke	Thyroid Disease	Ulcers
Mother	___ Alive ___ Deceased																						
Father	___ Alive ___ Deceased																						
Sister	___ Alive ___ Deceased																						
Brother	___ Alive ___ Deceased																						

Social History:

Do you use tobacco products? Yes No Quit Date: ________
If Yes, are you ready to Quit? Yes No Packs per day?__________________ # Years? ___________
Do you use smokeless Tobacco? Yes No Quit Date: ________
If Yes, are you ready to Quit? Yes No
Do you drink alcohol? Yes No Drinks per week? _________________
If Yes, drinks per week: Wine _______ Beer _______ Liquor _______
Do you use recreational drugs? Yes No
If Yes, use per week? ____________________ Type: _______________________
Do you exercise? Yes No
If Yes, how often? ______________________ Type: _______________________
Do you live alone? Yes No
If No, with whom do share a household? ____
Are you currently working? Full Time Part Time Not Working Retired

Occupation: ____