CAROLINA SURGERY & CANCER CENTER, PLLC

advanced personal care close to home

PATIENT INFORMATION RECORD

Name:_____ Date of Birth:_____

Referring MD: _____

Chief Complaint: _____

Social History: Occupation_____

Cigarette Use _____ Caffeine _____ Alcohol _____ Drugs _____

PAST MEDICAL HISTORY: (Circle if you have been diagnosed with the condition.)

High Blood Pressure	Diabetes	COPD	Ulcers
Heart Attack	Liver Problems	TB	Reflux
Stroke	Hepatitis	Asthma	Cancer
Heart Disease	Kidney Problems	Seizures	HIV / AIDS
Heart Failure	Bleeding Problems	Thyroid Problems	Depression

HOSPITALIZATIONS / SURGERIES:

REASON	DATE	LOCATION	DETAILS

ALLERGIES: (Please list all allergies including medications, foods, latex, etc...)

CURRENT MEDICATIONS: (Including alternative medications / vitamins / supplements / herbs)

NAME	DOSE	FREQUENCY	NOTES

Patient Signature_____