Western Carteret Medical Center

718 Cedar Point Blvd, Cedar Point NC 28584
(p) 252-393-6543 (f) 252-393-6545

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____ STATE: _____

PHONE NUMBER: _____ EMAIL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

SEX: M /F / OTHER **MARITAL STATUS:** S M W D

RACE: ASIAN BLACK NATIVE AMERICAN WHITE HISPANIC OTHER

PREFERRED METHOD OF CONTACT: MAIL PORTAL TEXT PHONE

***DO YOU GIVE WESTERN CARTERET MEDICAL CENTER PERMISSION TO SEND YOU EMAIL AND TEXT REMINDERS FOR YOUR APPOINTMENTS?** YES NO

IF UNDER THE AGE OF 18, PLEASE INCLUDE GUARDIAN INFORMATION**

NAME: _____ PHONE NUMBER: _____

Patient Name

SOCIAL SECURITY NUMBER:_____

EMERGENCY CONTACT :_____

PHONE NUMBER:_____ RELATIONSHIP TO YOU:_____

PRIMARY INSURANCE:
POLICY HOLDER:_____

_____

POLICY HOLDER'S DATE OF BIRTH:_____

RELATIONSHIP TO POLICYHOLDER:_____

POLICY#_____

GROUP#_____

DATE OF ELIGIBILITY:_____

INSURANCE PHONE NUMBER:_____

SECONDARY INSURANCE:
POLICY HOLDER:_____

_____

POLICY HOLDER'S DATE OF BIRTH:_____

RELATIONSHIP TO POLICYHOLDER:_____

POLICY#_____

GROUP#_____

Patient Name

DATE OF ELIGIBILITY:_____

INSURANCE PHONE NUMBER:_____

Medical History

ALLERGIES: ☐ NO ALLERGIES (check box)
(please include reaction)

_____

_____

MEDICATIONS:

☐ NO MEDICATIONS (check box)

LIST ALL MEDICATIONS, EVEN OVER THE COUNTER MEDICATIONS

MEDICATIONS	DOSE (ex: 200mg)	TIMES PER DAY

PLEASE ADD YOUR PREFERRED PHARMACY (please indicate city)

_____

_____

HEALTH MAINTENANCE SCREENINGS HISTORY

***IF DATE IS UNKNOWN PLEASE INDICATE IF YOU HAVE **EVER** HAD PROCEDURE**

EXAM	DATE	DOCTOR	NORMAL (Y/N)
PSA (men only)			
COLONOSCOPY			
MAMMOGRAM			
PAP SMEAR			
BONE DENSITY			

Patient Name

EYE EXAM			
DENTAL EXAM			

VACCINATION HISTORY:

Last tetanus:_____Last Flu Vaccine_____

Last Zoster (Singles):_____ Last Prevnar:_____

Have you ever been screened for Hepatitis C before?_____

WOMEN'S HEALTH HISTORY:

AGE OF FIRST PERIOD:_____DATE OF LAST MENSTRUAL CYCLE:_____
AGE MENOPAUSE STARTED:_____
TOTAL NUMBER OF PREGNANCIES:_____NUMBER OF LIVE BIRTHS:_____
NUMBER OF MISCARRIAGES:_____NUMBER OF ABORTIONS:_____

PERSONAL MEDICAL HISTORY (all about YOU) (PLEASE CIRCLE ALL THAT APPLY)

HIGH BP STROKE/TIA DEPRESSION ANXIETY DIABETES

CANCER(_____) KIDNEY DISEASE ASTHMA/EMPHYSEMA HIGH CHOLESTEROL

OTHER_____

SURGERY HISTORY: ***PLEASE INDICATE WHICH SIDE (EX: LEFT OR RIGHT)***

TYPE:_____DATE:_____LOCATION:_____
TYPE:_____DATE:_____LOCATION:_____
TYPE:_____DATE:_____LOCATION:_____
TYPE:_____DATE:_____LOCATION:_____

FAMILY MEDICAL HISTORY (all about your FAMILY) ☐ IF FAMILY HISTORY IS UNKNOWN (check box) ***CHECK ALL THAT APPLY TO YOUR FAMILY MEMBERS****

CONDITION	MOTHER	FATHER	SIBLING	MATERNAL GRANDPARENTS	PATERNAL GRANDPARENTS
STROKE					
CANCER(type_____)					
DIABETES (type_____)					
HEART DISEASE					

SUBSTANCE HISTORY:

TOBACCO USE: DO YOU SMOKE CIGARETTES? Y OR N

Patient Name

CURRENT: PACKS PER DAY_____ # OF YEARS_____ HOW LONG_____ PAST: QUITE DATE_____HOW LONG_____HOW MUCH_____

If using other tobacco products or nicotine products, please indicate the type of product:_____

ALCOHOL USE: DO YOU DRINK ALCOHOL? Y OR N

OF DRINKS/WK?_____

□BEER □WINE □LIQUOR

DRUG USE:

DO YOU USE RECREATIONAL DRUGS/ OR HAVE YOU EVER?_____

DO YOU USE MARIJUANA?_____

SEXUAL ACTIVITY:

Are you currently sexually active? □ yes □no

How many partners have you had in the last year? □ 0 □1 □ more than 1

Sexually active with: □ men □women □both

Currently using birth control? □yes □no

If yes, please indicate what you are using_____

OVERALL HEALTH:

1. How many hours of sleep do you get on average?_____
2. How would you rate your diet? □fair □good □bad
3. Would you like advice on your diet? □yes □no
4. Do you have any concerns for safety in your home? □yes □no
5. Do you have an advanced directive or living will? □yes □no

Is there anything else that you would like the provider to know about your current or past medical conditions:

_____

_____