CARY MEDICAL CLINIC
550 NEW WAVERLY PLACE - SUITE 105
CARY, NC 27518

DR. NEELU AGARWAL **DR. ABHAY AGARWAL**

PATIENT QUESTIONNAIRE

DATE

NAME: | DATE OF BIRTH

OCCUPATION / EMPLOYMENT | HIGHEST LEVEL OF EDUCATION

REASON FOR VISIT

HOSPITALIZATIONS — ***IF YOU HAVE BEEN IN A HOSPITAL OVERNIGHT - STATE THE YEAR - ILLNESS / OPERATION (PLEASE START WITH THE MOST RECENT EVENT)***

YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION

PAST MEDICAL & FAMILY HISTORY — **PLEASE CHECK IF YOU (SELF) OR ANY BLOOD RELATIVE HAS ANY OF THE FOLLOWING CONDITIONS -**

	SELF	RELATION		SELF	RELATION
01) RECENT WEIGHT LOSS			17) KIDNEY / BLADDER PROB.		
02) MIGRAINE HEADACHES			18) NEUROLOGICAL		
03) EPILEPSY / CONVULSIONS			19) ARTHRITIS		
04) EYE DISEASE			20) OSTEOPOROSIS		
05) HEARING DISORDER			21) CANCER - TYPE:		
06) RECURRENT-NOSE BLEEDS					
SINUS / THROAT INFECT(S)			22) BLEEDING DISORDER		
07) ANGINA - CHEST PAIN			23) BLOOD TRANSFUSIONS)		
08) HEART ATTACK			24) ANEMIA		
09) HIGH BLOOD PRESSURE			25) DIABETES		
10) STROKE			26) THYROID		
11) HIGH CHOLESTEROL			27) ALCOHOL OR DRUG ABUSE		
12) HEART VALVE DISORDER			28) MENTAL ILLNESS		
13) LUNG DISEASE			29) DEPRESSION		
14) STOMACH ULCER			30) PSORIASIS		
15) BOWEL PROBLEMS			31) HAIR LOSS □PROGRESSIVE □RECENT		
16) LIVER DISEASE/ HEPATITIS			32) ACCIDENT - MAJOR		

LIST ALL MEDICATIONS YOU TAKE

MEDICATION	DOSE	TIMES/DAY

DO YOU NOW OR HAVE EVER CONSUMED -

CIGARETTES	Y	N	PACK / DAY ____ #YRS ____
ALCOHOL	Y	N	DRINKS / WK _____
COFFEE / TEA	Y	N	CUPS / DAY _____
STREET DRUGS	Y	N	TYPE _____
EXERCISE	Y	N	_____ Min/day
			_____ Times/week

THE LAST TIME YOU HAD A - (YEAR)

FLU VACCINE		TETANUS SHOT	
HEPATITIS VACCINE		PNEUMONIA SHOT	
T.B. TEST		RECTAL EXAM	
STOOL BLOOD TEST		EYE EXAM	
DENTAL EXAM		COLONOSCOPY	
CHOLESTEROL TEST		*(result)*	

DRUG ALLERGIES

DRUG	REACTION

FOR WOMEN ONLY

DATE OF LAST PERIOD _____

ARE YOU USING BIRTH CONTROL Y N

TYPE: _____

NUMBER OF PREGNANCIES _____

NUMBER OF BIRTHS _____

NUMBER OF ABORTIONS _____

NUMBER OF MISCARRIAGES _____

YEAR OF LAST -

____ PAP TEST □ NORMAL □ ABN

____ BREAST EXAM □ NORMAL □ ABN

____ MAMMOGRAM □ NORMAL □ ABN

THE LAST TIME YOU HAD A COMPLETE PHYSICAL DATE: _____

*** PLEASE NOTE THAT ANY COMPLETE PHYSICAL DONE BEFORE YOUR INSURANCE CONTRACT PLAN COVERAGE WILL BE BILLED DIRECTLY TO PATIENT***

DO YOU HAVE ANY OTHER PROBLEM FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? - PLEASE LIST THEM

ARE YOU HAVING ANY SYMPTOMS THAT YOU WOULD LIKE TO DISCUSS? PLEASE LIST THEM

Chart # _____