

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

DR. NEELU AGARWAL

DR. ABHAY AGARWAL

PATIENT QUESTIONNAIRE	DATE _____
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NAME: _____	DATE OF BIRTH _____
OCCUPATION / EMPLOYMENT _____	HIGHEST LEVEL OF EDUCATION _____

REASON FOR VISIT	_____
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HOSPITALIZATIONS				<i>IF YOU HAVE BEEN IN A HOSPITAL OVERNIGHT - STATE THE YEAR - ILLNESS / OPERATION (PLEASE START WITH THE MOST RECENT EVENT)</i>			
YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION	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				22) BLEEDING DISORDER		
SINUS / THROAT INFECT(S)				23) BLOOD TRANSFUSIONS)		
07) ANGINA - CHEST PAIN				24) ANEMIA		
08) HEART ATTACK				25) DIABETES		
09) HIGH BLOOD PRESSURE				26) THYROID		
10) STROKE				27) ALCOHOL OR DRUG ABUSE		
11) HIGH CHOLESTEROL				28) MENTAL ILLNESS		
12) HEART VALVE DISORDER				29) DEPRESSION		
13) LUNG DISEASE				30) PSORIASIS		
14) STOMACH ULCER				31) HAIR LOSS ^{PROGRESSIVE} _{RECENT}		
15) BOWEL PROBLEMS				32) ACCIDENT - MAJOR		
16) LIVER DISEASE/ HEPATITIS						

LIST ALL MEDICATIONS YOU TAKE			DO YOU NOW OR HAVE EVER CONSUMED -			DRUG ALLERGIES	
MEDICATION	DOSE	TIMES/DAY				DRUG	REACTION
			CIGARETTES	<input type="checkbox"/> Y	<input type="checkbox"/> N	PACK / DAY _____ #YRS _____	
			ALCOHOL	<input type="checkbox"/> Y	<input type="checkbox"/> N	DRINKS / WK _____	
			COFFEE / TEA	<input type="checkbox"/> Y	<input type="checkbox"/> N	CUPS / DAY _____	
			STREET DRUGS	<input type="checkbox"/> Y	<input type="checkbox"/> N	TYPE _____	

	EXERCISE	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Min/day _____ Times/week	FOR WOMEN ONLY	
				DATE OF LAST PERIOD _____	
				ARE YOU USING BIRTH CONTROL	<input type="checkbox"/> Y <input type="checkbox"/> N
				TYPE: _____	
				NUMBER OF PREGNANCIES	_____
				NUMBER OF BIRTHS	_____
				NUMBER OF ABORTIONS	_____
				NUMBER OF MISCARRIAGES	_____
				YEAR OF LAST -	_____
				PAP TEST	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABN
				BREAST EXAM	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABN
				MAMMOGRAM	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABN

THE LAST TIME YOU HAD A COMPLETE PHYSICAL	DATE: _____
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*** 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
