HOT SPRINGS
HEALTH PROGRAM

Mail or Fax all Correspondence to:
590 Medical Park Drive
P.O. Box 69
Marshall, NC 28753
P: (828) 649-9566
F: (828) 649-2780

MARS HILL MEDICAL CENTER
119 Mountain View Road
Mars Hill, NC 28754
P: (828) 689-3507
F: (828) 649-2780

MASHBURN MEDICAL CENTER
590 Medical Park Drive
Marshall NC, 28753
P: (828) 649-3500
F: (828) 649-2780

HOT SPRINGS MEDICAL CENTER
66 NW US 25/70 HIGHWAY
Hot Springs, NC 28743
P: (828) 622-3245
F: (828) 649-2780

LAUREL MEDICAL CENTER
80 Guntertown Road
Marshall, NC 28753
P: (828) 656-2611
F: (828) 649-2780

New Adult Patient Questionnaire

Today's Date: _____ Date of Birth: _____

Name: _____ Nickname: _____

Email Address: _____

By providing your email address, you authorize to be enrolled in our patient portal. The portal enables you to securely view lab/test results, comments your provider has made about your lab/test results, medication list, immunizations, past & upcoming appointment dates, and send/receive messages securely to/from our staff.

Please list the names of other doctors you currently see: (Example: kidney doctor, gynecologist, etc.)

_____

In addition to listing them below, please BRING ALL medications, supplements and vitamins to your appointment, in their original bottles!

Prescription Medications (daily meds and ones taken as needed):

Name of Medication	Dose size (usually mg) / # tabs	How Often Taken

Non-Prescription Medications, Vitamins, Herbs, Supplements (daily and ones taken as needed):

Name	Dose	How Often Taken	Reason Taken

Allergies or bad reactions to medicines.

Please list the medicines you're allergic to and reaction(s) the medication caused.

☐ No allergies or adverse reactions to drugs

Medicine	Reaction it Caused

PLEASE COMPLETE BOTH SIDES OF EACH PAGE

PLEASE CHECK OFF ALL CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH:

Alcoholism	☐	High Blood Pressure	☐
Arthritis	☐	High Cholesterol	☐
Asthma	☐	History of Physical Abuse	☐
Cancer	☐	History of Sexual Abuse	☐
Constipation	☐	Kidney Stones	☐
Diabetes	☐	Mental Illness	☐
Diverticulosis	☐	Pneumonia	☐
Emphysema (COPD)	☐	Prostate Trouble	☐
Exposure to Toxic Chemicals	☐	Seizures	☐
Gallstones	☐	Stroke	☐
Headaches	☐	Thyroid Trouble	☐
Heart Attack	☐	TB or positive TB Test	☐
Heart Trouble	☐	Ulcers	☐
Hepatitis (Jaundice)	☐	Venereal Disease	☐

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

Type of Surgery	Date of Surgery	
Adenoids out ☐		
Appendix out ☐		
Tonsils out ☐		
Gallbladder out ☐		
Heart surgery ☐		Describe:
Hernia Repair ☐		Which Side:
Uterus removed ☐		If uterus removed, why:
Ovaries removed ☐		☐ Left ☐ Right ☐ Both
Other Surgeries:		

List any hospitalizations (other than surgery) you have had: (List dates if possible)

_____

List any serious illnesses (pneumonia) or injuries (broken bone) you have had: (List dates if possible)

Health Maintenance

For Women Only

Date of last Mammogram: ____/____/____ Where was Mammogram done? _____
Was it normal? ☐ Yes ☐ No

Date of last Pap smear: ____/____/____ Where was Pap done? _____
Was your last pap smear normal? ☐ Yes ☐ No

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

How many pregnancies _____ ☐ None. How many live births: _____ How many miscarriages: _____

How many C-sections: ___ Age your periods started: _____Age your periods ended (if applicable): _____

Health Maintenance

Have you had any of the following vaccines?	Date(s)	Where did you receive the vaccine?
Pneumonia-Conj. Vaccine (Prevnar 13)		
Pneumonia-Poly. Vaccine (Pneumovax)		
Flu Shot		
Tetanus Shot-(TD) If yes, did tetanus include whooping cough? (Tdap) ☐ Yes ☐ No		
Shingles Immunization	**Date**	**Where**
Zostavax		
Shingrix		
Please list dates of exams/tests you have had.	**Date**	**Where**
Eye Examination		
Bone Density Test (DEXA Scan)		
Colon Cancer Screening	**Date**	**Where**
Colonoscopy		
Cologuard		
FOBT (stool cards to check for blood)		
For patients who smoke/or formally smoked only	**Date**	**Where**
Abdominal Ultrasound to check for Abdominal Aortic Aneurysm		
CT Scan of the lungs		

SOCIAL HISTORY

☐ Single / ☐ Married since _____ Check one: ☐ 1st ☐2nd ☐3rd ☐ 4th ☐5th marriage.
☐ Divorced since _____ / ☐ Widowed since _____ / ☐ Not married, living together since _____
Name of Significant Other/Spouse if applicable: _____
Do you have children? ☐ Yes ☐ No /If so, how many & ages- Son(s) _____Daughter(s) _____

The following people currently make up my household:

Name	Age	Relation to me

Sexual Orientation	Please Check
Choose not to disclose	
Straight, not Lesbian or Gay	
Lesbian, Gay or Homosexual	
Bi-Sexual	
Other	
Don't Know	

Gender Identity	Please Check
Choose not to disclose	
Female	
Male	
Transgender (Female-to-Male)	
Transgender (Male-to-Female)	
Other	

Occupation
☐ Retired since _____/ ☐ Unemployed since _____/ ☐ Disabled since_____/ ☐ Homemaker since ____
Currently employed at _____Doing _____ Since_____
Former Job(s) _____
Education: What is your highest level of education? _____
Do you exercise ☐ Yes ☐ No / If yes, please list what kind of exercise you do and how often:

_____

Alcohol use: On average, how many alcoholic beverages do you drink per week? _____
Tobacco Use: Do you currently smoke cigarettes ☐ Yes ☐ No ☐ Never
If yes, I smoke ____ packs per day.
Not smoking now. I quit in _____ (year) after smoking _____ ppd for _____ years.
Other tobacco use: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Substance Abuse: History of addiction? ☐ Yes ☐ No. History of IV drug use? ☐ Yes ☐ No
Advance Directives: Have you filled out forms to indicate your desires for end of life care? ☐ Yes ☐ No
☐ Living will ☐ Durable power for health care ☐ Other_____

Are any of the following problems present in your household?

Alcohol or other substance abuse ☐ Yes ☐ No Stable housing ☐ Yes ☐ No
Caregiver problems or issues ☐ Yes ☐ No Getting/keeping health insurance ☐ Yes ☐ No
Do you feel **un**safe in your relationship or is anyone in your life hurting you? ☐ Yes ☐ No
In the past 6 months, did you/your family go without food because of money? ☐ Yes ☐ No
Has lack of transportation kept you from getting the things you need? ☐ Yes ☐ No
There are programs to help with needs that can affect health, but they aren't reaching everyone who may need them.
Would you like to be contacted to see if there are resources that might help with any of the questions above?
☐ *Yes* ☐ *No* *If yes, what phone number would you like us to use to contact you? _____

Family History

(Indicate which relative has had the following diseases)

*If some siblings are alive and some are deceased use the space to the right to explain further.	Mother	Father	*Brother(s)	*Sister(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	
Alive									
Deceased									
Age currently or at death									

	Mother	Father	Brother(s)	Sister(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other blood relatives (list relationship to you)
Alcoholism									
Asthma									
Breast Cancer									
Cholesterol									
Colon/Rectal Cancer									
COPD									
Diabetes Mellitus									
Fibromyalgia									
Gallstones									
Genetic Disorder									
Heart Disease									
Hypertension									
Kidney Disease									
Liver disease									
Nerves/Depression/ Bipolar									
Obesity									
Other Cancer									
Rheumatoid Arthritis									
Stroke									
Other:									