SOUTH CHARLOTTE GENERAL & VASCULAR SURGERY, PLLC.
10512 Park Rd. Suite 111, Charlotte, North Carolina, 28210 Phone: 704-910-8380 Fax: 704-817-9980

New Patient Questionnaire

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) – Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	Dose	How Often	Prescribing Doctor

Please list and describe allergic reactions you have to medications.

Check if you are allergic to _____ IV Contrast _____ Penicillin's _______ Latex

Allergies:

____

____

____

Tobacco Use History

Do you currently smoke? Yes No (circle one) ____# of packs per day ____ # of years

Have you ever smoked? Yes No (circle one) ____# of packs per day ____ # of years

Alcohol Use History

Do you now, or did you once, regularly drink alcohol? Yes No (circle one)

_______ # of drinks per day week (circle one)

Surgical History

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

____

Patient's Signature Date