Medical History

Name: _____

DOB: ____/____/_____

Reason for today's visit: _____ (please specify if you are looking to discuss any issue(s) or medication(s))

Current Medications:

Medication	Strength & Formulation	Take	Frequency
Example: Metformin	1000 MG Tablet	One tablet	Twice a day with meals
Over-the-counter vitamins/supplements (baby aspirin, omega 3, etc.):			

PLEASE ATTACH A LIST, IF MEDICATIONS EXCEED SPACE PROVIDED

Medical History (check all that apply):

ADD		COPD / Emphysema		Other:
A-fib		Depression		_____
Allergies		Diabetes (type I or II)		_____
Alzheimer's / Dementia		Heart Disease (type)-		_____
Anxiety		Hyperlipidemia (high cholesterol)		_____
Arthritis		Hypertension (high blood pressure)		_____
Asthma		Stroke		_____
Cancer (type)-		Thyroid Problems (hyper / hypo)		_____
				_____

Drug Allergies / Allergens:

Allergen (medication, food, etc.)	Reaction

Surgical History:

Surgery	PLEASE provide the year or approximate year (even if "as a child")

Family History:

****PLEASE provide the year of birth (if alive) or age of death (if deceased)****

	Mother	Father	Sibling	Sibling	Paternal GF	Paternal GM	Maternal GF	Maternal GM
year of birth (if alive) or age of death (if deceased)								
Diabetes								
Hypertension								
Heart Disease								
Hyperlipidemia								
Cancer (type)-								
Colon Polyps								
Unknown								
Stroke								
Thyroid Problems								
Mental Illness								
Glaucoma								
Abdominal Aortic Aneurysm								
Other:								

Social History:

Tobacco

- Have you ever smoked? Yes · No
  Current Smokers
- How many cigarettes per day? ____
- How many years have you smoked? ____
  Former Smokers
- How many cigarettes did you smoke per day? ____
- How many years did you smoke for? ____
- At what age did you quit? ____

Alcohol

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 point)
- ☐ Monthly or less (1 point)
- ☐ 2 to 4 times a month (2 points)
- ☐ 2 to 3 times a week (3 points)
- ☐ 4 or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks (0 point)
- ☐ 3 or 4 drinks (1 point)
- ☐ 5 or 6 drinks (2 points)
- ☐ 7 to 9 drinks (3 points)
- ☐ 10 or more drinks (4 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never (0 point)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

- Do you or have you used illegal drugs? Yes · No
- If yes, please specify. _____

- Do you exercise? Yes · No
  If yes, what type? _____ How often? _____

- Do you wish to be tested for STD's? Yes · No

- Do you ever feel afraid of your partner? Yes · No

- Do you have a living will? Yes · No

Date of (most recent) Immunizations:
Please try to provide at least approximate month & year or circle other option

Flu shot	____/____/____ · Refuse flu shots
Tetanus shot	____/____/____ · Don't remember
Pneumonia vaccine	____/____/____ · Never had
Shingles vaccine	____/____/____ · Never had

Last Preventative:
Please try to provide an approximate date of service for each service, if you have never had done please just put "N/A." For location/Dr. please provide us with the name of an ordering specialist (GI, GYN), radiology service center (South Jersey Radiology, Larchmont Imaging, etc.) or lab draw station (LabCorp, Quest, etc.). For results please put if testing was normal or abnormal and specify. Thanks!

Service/Test	Date	Location/Dr.	Result
Annual Wellness Exam	__/__/____	Last PCP:	
Bloodwork	__/__/____	LabCorp Quest Other:	
Eye Exam	__/__/____	Ophthalmologist:	
Colonoscopy	__/__/____	GI:	○ Normal ○ Polyps ○ Abnormal:
Pap Smear	__/__/____	GYN:	○ Normal ○ Abnormal:
Mammogram	__/__/____		○ Normal ○ Abnormal:
Dexa Scan	__/__/____		○ Normal ○ Osteopenia ○ Osteoporosis
Ultrasound Abdominal Aorta	__/__/____		○ Normal ○ Abdominal Aortic Aneurysm
EKG	__/__/____	Cardiologist:	○ Normal ○ Abnormal:

Are you followed by any other doctors?

Doctor's Name	Specialty	Phone #

Any other Information we need to know about you?