Date: ____/____/_____ Date of Birth: _____

Name: _____

Height: Weight: Age:

ALLERGIES: Y__ N__ DRUGS:_____ Reaction:_____

Latex Sensitive: Y N FOODS: Reaction:

Reasons For Visit/Chief Compliant:

_____

_____

_____

PAST MEDICAL HISOTRY

1.Hypertention Y__ N__

2. Diabetes Y__ N__

3. Other:

PAST SURGICAL HISTORY

Surgery:_____ Year_____

Surgery:_____ Year_____

Surgery: Year

Social History

Occupation:_____ Employed:_____ Retired:_____ Disabled:_____

Tobacco Use Within last 12?: Y__N__ Amt:____ How long: _____ Quit:_____

For Smoking Cessation: I will call Tobacco Control Center at 516-466-1980: Y__ N__

Alcohol Use: Y___ N___ Type:_____ Quantity:_____ Freq:_____ Date of last drink:_____

Illicit Drug Use: Y_____ N_____ Type:_____ How Long:_____ Freq.:_____

Do You Have Kids?:_____ Caffeine Use(coffee, tea, soft drinks):Y___ N____Amt:_____How Long:_____

Marital Status: Single _____ Divorced_____ Widow_____

Do have any tattoos? Y N Acupuncture? Y N

FAMILY HISTORY

Father Age:____ Living/ Deceased Cause of Death _____

Mother Age:____ Living/Deceased Cause of Death_____

Brother/Sister (s) Age:____ #Living__ #Dead___ Cause(s) of Death_____

Mother/Father	Ulcerative Colitis	Stroke	High Blood Pressure	Diabetes	Cancer	Crohn's	Liver Disease
Siblings	Ulcerative Colitis	Stroke	High Blood Pressure	Diabetes	Cancer	Crohn's	Liver Disease

PRESENT ILLNESS/PAIN

Are you experiencing pain? Y__ N__

If yes, location of pain:

Rate of pain on a scale of 0 to 10(0-None, 5-Moderate, 10-Worst) 1 2 3 4 5 6 7 8 9 10

Describe the problem? Dull to Sharp____ Very Sharp____ Sharp then Leaves_____ Constant_____

When did you notice the problem? Today___ Days Ago____ Weeks Ago___ Months Ago____

How long does the problem last? 30 Mins._____ 1Hour_____ Its always there_____

What makes the pain better? Moving Around_____ Standing Up_____ Lying_____ Other_____

What makes the pain worse? Moving Around_____ Standing Up_____ Lying_____ Other_____

Does anything else occur at the same time? YES__ NO__ Rash__ Nausea___ Headache___ Fever_____

Other__ (please describe)_____

Does the problem interfere with your normal daily activity? YES NO Explain

Patient Name:_____

MEDICATIONS
(Prescription or non-prescription)

Medication Name	Dosage	Frequency	Time of Last Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vitamins(e.g Vit E):_____ Herbs(e.g teas/drinks)_____ Oral Contraceptives: Y/N _____

IMMUNIZATIONS/VACCINES
Influenza Y__ N__ Pneumococcal Y__ N__ Hepatitis A Y__ N__ Hepatitis B Y__ N___

ADVANCE DIRECTIVES: If you have an advanced directive please provide the office with a copy:

Do you have an Advanced Directive? Y/N. If no, would you like assistance in completing one? Y/N

(If yes- Patient should call Social Work Department at 516-562-8415.) *Ask Medical Assistant for a brochure*

REVIEW OF SYSTEMS

Do you now have or have you had any of the following problems?

General Symptoms	Skin	Gastrointestinal	Hematologic
Fever Y/N Chills Y/N Headache Y/N Other:_____	Rash Y/N Itch Y/N Eczema Y/N	Abdominal Pain Y/N Nausea/Vomiting Y/N Heartburn Y/N Ulcers Y/N Diarrhea Y/N Indigestion Y/N Constipation Y/N Food intolerance Y/N Hemorrhoids Y/N Rectal Bleeding Y/N Other:_____	Swollen Glands Y/N Blood Clotting Y/N Anemia Y/N Other:_____

Allergic/Immunologic	Musculoskeletal	Cardiovascular	Psychological
Allergies Y/N Hay Fever Y/N Other: _____	Joint Pain Y/N Neck Pain Y/N Back Pain Y/N Other: _____	Chest Pain Y/N High blood Pressure Y/N Varicose Veins Y/N	Depression Y/N Afraid of Anyone Y/N Anxiety/ Stress Y/N Attempt Suicide Y/N

Eyes	Ear/Nose/Throat/Mouth	Respiratory	Gynecological
Blurred Vision Y/N Double Vision Y/N Pain Y/N Other:_____	Ear Infection Y/N Sore Throat Y/N Sinus Problems Y/N Other:_____	Wheezing Y/N Cough Y/N Shortness of Breath Y/N Other:_____	Last Menstruation:_____ Pap Smear:_____ Breast Exam:_____ Pregnancies:_____ N/A:_____

Neurological	Urinary	OTHER:
Tremors Y/N Dizziness Y/N Numbness Y/N Other:_____	Urinary retention Y/N Painful Urination Y/N Urinary Frequency Y/N Other:_____	

Patient Signature:_____Date:_____Physician Signature:_____Date:_____