**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**



* 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 | \_\_/\_\_/\_\_\_\_ | LabCorpQuestOther: |  |
| 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?**