Name: ____

YOUR MEDICAL CONDITIONS (check all that apply)

❑ Allergies
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Blood transfusion
❑ Cancer
❑ Clotting disorder
❑ Congestive heart failure
❑ Depression
❑ Diabetes mellitus
❑ Emphysema/COPD
❑ Gastroesophageal reflux disease (GERD)
❑ Glaucoma
❑ Heart murmur
❑ HIV/AIDS
❑ High cholesterol
❑ Hypertension/high blood pressure
❑ Kidney disease
❑ Myocardial infarction
❑ Nerve/muscle disease
❑ Osteoporosis
❑ Seizures
❑ Sickle cell anemia
❑ Substance abuse
❑ Thyroid disease
❑ Tuberculosis

Details/Other: ____

SURGICAL HISTORY (check all that apply)

❑ Appendectomy
❑ Brain surgery
❑ Breast surgery
❑ CABG
❑ Cholecystectomy
❑ Colon surgery
❑ Tonsillectomy
❑ Appendectomy
❑ Thyroid surgery
❑ Lung surgery
❑ C-section
❑ Eye surgery
❑ Fracture surgery
❑ Hernia repair
❑ Hysterectomy
❑ Joint surgery
❑ Bunionectomy
❑ Varicose vein surgery
❑ Prostate surgery
❑ Weight reduction surgery
❑ Small intestine surgery
❑ Spine surgery
❑ Tubal ligation
❑ Valve replacement
❑ Vasectomy
❑ Vascular surgery
❑ Cardiac stent
❑ Bladder surgery

Have you ever had a blood transfusion? ❑ No ❑ Yes, approximate dates: ______________________________

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history: ____

HABITS AND ACTIVITIES

Do you use tobacco? ❑ No ❑ Yes, what form? ______________ How much?______________ For how long?________
❑ In the past How many years ago did you quit? ______________
Have you tried to quit? ❑ No ❑ Yes Would you like to quit? ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ In the past ❑ Yes, how many drinks per week? ______________________

Do you, or have you ever used recreational drugs? ❑ No ❑ Yes, describe: ______________________________

Do you get regular exercise? ❑ No ❑ Yes, what kind of exercise?
How often? ❑ Daily ❑ N Name: ____

List any hobbies or leisure activities:

____

Name: ______________________________

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)	____________	❑
Tetanus booster (Tdap)	____________	❑
TB skin test (PPD)	____________	❑
Hepatitis B vaccine	____________	❑
Hepatitis A vaccine	____________	❑
Varicella (chicken pox)	____________	❑
Shingles (Zostavax)	____________	❑

PREVENTIVE CARE

Test or Procedure	Date and Result	Never
Colonoscopy	____________	❑
Bone density test (DXA)	____________	❑
Cholesterol test	____________	❑
PSA (prostate cancer test)	____________	❑
Pap smear	____________	❑
Mammogram	____________	❑
HIV test	____________	❑

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.): ______________________________

____

SEXUAL HISTORY

My sexual partners have been: ❑ Male ❑ Female ❑ Both ❑ Never Sexually Active

Have you had more than one sexual partner in the past year? ❑ No ❑ Yes

Have you ever had a sexually transmitted disease? ❑ No ❑ Yes, what and when? ______________

GYNECOLOGICAL AND OBSTETRIC HISTORY

How many times have you been pregnant? ______ Live births? ______ Miscarriages? ______ Abortions? ______

Do you use contraception? ❑ No ❑ Yes, what kind? ______________________________

What was your age at first menses? ______ Menstrual periods: ❑ Regular ❑ Irregular ❑ Menopausal

Age at menopause? ______ Do you have hot flashes or other symptoms (specify)? ______________

Any gynecological conditions or problems? ______ Name: ______________________________

OTHER HEALTH ISSUES

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? ❑ No ❑ Yes, describe: ______________________________

Family Care

Name: ____

ALLERGIES List medication allergies and the type of reaction you had. ❑ **I have no drug allergies**

________________________________ ________________________________

________________________________ ________________________________

MEDICATIONS List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed. ❑ **None**

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

ADDITIONAL COMMENTS OR CONCERNS

____

____

____

____

____

SPECIALISTS INVOLVED IN YOUR CARE____

____

____

If you are a new patient or have been treated by another physician please complete a medical release form to have medical records forwarded to Family Care so we can provide the best care for you.

For more information about transferring your medical records to Family Care, contact Family Care 732-968-7878

Family Care
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Green Brook, NJ 08812
Phone (732) 968-7878
Fax (732) 968-7557