Family Care

PATIENT INFORMATION

LAST NAME:_____ **MIDDLE INIT.**____ **FIRST NAME:**_____

ADDRESS:_____**CITY:**_____**STATE/ZIP:**_____

HOME TELEPHONE:_____ **CELL PHONE:**_____

EMAIL ADDRESS:_____**(For non-confidential communication)**

DATE OF BIRTH:_____ **MARITAL STATUS: S M D W (CIRCLE) SEX: M F**

SOCIAL SECURITY NUMBER:_____

OCCUPATION:_____

EMPLOYER:_____

INSURANCE INFORMATION

MEDICAL INSURANCE COMPANY:_____
POLICY NUMBER:_____

NAME OF POLICY HOLDER:_____

SOCIAL SECURITY NUMBER:_____ **DATE OF BIRTH:**_____

EMERGENCY NOTIFICATION

In case of emergency, notify: _____ **TELEPHONE NUMBER:**_____

Relationship:_____

Today's Date:_____

257 Route 22 East
Green Brook, NJ 08812
Phone (732) 968-7878
Fax (732) 968-7557

Family Care

Name: _____

YOUR MEDICAL CONDITIONS (check all that apply)

- ❑ Seasonal Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer Type _____
- ❑ 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
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ 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
- ❑ Thyroid surgery
- ❑ Lung surgery
- ❑ C-section
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint surgery
- ❑ Bunionectomy
- ❑ Varicose vein surgery
- ❑ Prostate surgery
- ❑ Weight reduction surgery
- ❑ Spine surgery
- ❑ Tubal ligation
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Vascular surgery
- ❑ Cardiac stent
- ❑ Bladder surgery
- ❑ Other _____ _____

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? _____
❑ 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 ❑ Monthly

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IMMUNIZATIONS

Vaccination	Year	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	_____	❑
Hepatitis C screen	_____	❑

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? _____

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 _____

ALLERGIES

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

Latex allergy? ❑ No ❑ Yes

_____ _____

_____ _____

MEDICATIONS

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

_____ _____

_____ _____

_____ _____

_____ _____

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 at (732) 968-7878.