Barnabas Health Medical Group | RWJBarnabas HEALTH

Women's Health Center

Name: _____

Date of Birth: ____/_____ /_____ □Male □ Female Today's Date: _____

What is the reason for today's visit? _____

□**No Known Allergies**

Allergies: □ Latex □ Food_____□ Medications: _____

MEDICATIONS: list all medications you take, (including over the counter, herbal, natural remedies)

HEALTH HISTORY: have you ever had or been diagnosed with having (check all that apply)

AIDS/HIV+		Cancer, *if yes* **Type/s:**					Kidney Disease		Rheumatic Fever		
Anemia		Cataracts		Heart Disease			Low Blood Pressure		Scarlet Fever		
Angina		Chickenpox		Heart Murmur			Lung Disease		Seizure/Epilepsy		
Arthritis		Depression/Anxiety		Hepatitis			Measles		Sleep Apnea		
Asthma/COPD		Dementia		Hemorrhoids			Migraines/Headaches		Smallpox		
Back Pain		Diabetes		Hernia			Mumps		Stomach Ulcers		
Bladder Infections		Digestive Disorders		High Cholesterol			Mitral Valve Prolapse		Stroke		
Bleeding Disorder		Diphtheria		Hives/Eczema			Pneumonia		Thyroid Disease		
Blood Clots (DVT or PE)		Frequent Infections		Hypertension			Polio		Tuberculosis		
Blood /Plasma Transfusion		Glaucoma		Infectious Mono			Pre-Diabetes		Venereal Disease		
Bronchitis		Gout		Jaundice/Liver Disease			Prostate Enlargement		Whooping Cough		
Any Other Disease/Illness:											

Have you had Surgery, or been Hospitalized? Have you been to the Emergency Room in the past year?

Type of Surgery/Reason for Hospitalization/ Reason for Emergency Room visit	**Date**

IMMUNIZATIONS (check if yes and indicate year of last injection)

	Vaccine	**Year**		**Vaccine**	**Year**
	Influenza			Zoster (Shingles)	
	Tetanus			Hepatitis B	
	Pneumonia			MMR (Measles, Mumps & Rubella)	
	Varicella (Chicken Pox)			Other:	
	Tdap (Tetanus, Diphtheria & Pertussis)				

Barnabas Health Medical Group | RWJBarnabas HEALTH

Name: _____ Date of Birth: __ /__ /____

HEALTH HABITS: check which apply (if current please indicate amount)

	Never	Past	Current	Amount
Tobacco Use				**# used per day:** **pack/s per day:**
Alcohol Use				
Drug Use				**Type:** **Frequency:**
Seat Belt Use				
Exercise				

HEALTH MAINTENANCE: Have you had any of the following? (if YES indicate when)

	NO	YES	DATE
Mammography (Females age 40-69)			
Pap Smear (Females age 18-75)			
Colonoscopy (age 50-75)			
Bone Density (age >65)			
Last Menstrual Period (females)			
Gynecologist (females)	**NAME**		
Date of Last Chest X-Ray			

FAMILY HISTORY

Relation	**√ If Alive**	**Age at Death**	**Medical conditions/ Cause of Death**
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents			

DO ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

Anemia		
Arthritis		
Asthma		
Blood Clots		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Stroke		
Other:		