RWJBarnabas HEALTH

Patient Name: _____ DOB: _____ Today's Date:_____

PAST MEDICAL HISTORY

Medical Problems/Diagnose	Date	Surgeries/Procedures	Date

SOCIAL HISTORY

Please check the responses that are appropriate	Comments
Have you ever smoked? Never ☐ Former ☐ Current☐ Cigarettes☐ Cigars ☐ Vaping☐ **If current smoker, how many packs per day?: packs per year?:**	
Do you drink alcohol? Yes ☐ No ☐ **If yes:** Beer ☐ Wine ☐ Liquor ☐ **If yes, how many drinks per week?:**	
Do you use drugs (illegal or prescription misuse)? Never ☐ Past ☐ Current ☐	
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Life Partner ☐	
Exercise: Yes ☐ No ☐ **If yes, type of exercise:** **How long do you exercise? How often?**	
Have you been sexually abused, threatened or hurt by anyone? Yes ☐ No ☐	
Do you have a living will or advanced directive? Yes ☐ No ☐ On file ☐ **Would you like to discuss?** Yes ☐ Declined ☐	

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FAMILY HISTORY

Relationship	Living Yes	Living No	Medical Problems (High blood pressure, Heart disease, Cancer, High cholesterol, Thyroid disease, Mental health, or other condition)
Father			
Mother			
Sibling			
Sibling			
Sibling			

Local Pharmacy: **Mail Order Pharmacy:**

MEDICATION HISTORY

Medication Allergies: Yes ☐ No ☐
If Yes, What Medication: **Type of Allergy Reaction:**

Food or Herbal Allergies: Yes ☐ No ☐
If Yes, What Food or Herbal: **Type of Allergy Reaction:**

Current medications (or attach list)	Strength	How often?	Who prescribed medication?

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Please check if you have any of these symptoms	YES	NO	N/A	Comments
EYES				
Double Vision	☐	☐	☐	
Spots Before Eyes	☐	☐	☐	
Vision Changes	☐	☐	☐	
EARS, NOSE AND THROAT/MOUTH				
Earache	☐	☐	☐	
Hearing Problems or Ringing in Ears	☐	☐	☐	
Sinus Problems	☐	☐	☐	
Sore Throat	☐	☐	☐	
CARDIOVASCULAR				
Chest Pain or Pressure	☐	☐	☐	
Swelling of Legs	☐	☐	☐	
Rapid or Irregular Heartbeat	☐	☐	☐	
RESPIRATORY				
Wheezing	☐	☐	☐	
Shortness of Breath	☐	☐	☐	
Chronic Cough	☐	☐	☐	
GASTROINTESTINAL				
Frequent Diarrhea or Constipation	☐	☐	☐	
Bloody Stool	☐	☐	☐	
Nausea/Vomiting/Heartburn	☐	☐	☐	
GENITOURINARY				
Blood in Urine	☐	☐	☐	
Pain with Urination	☐	☐	☐	
Frequent Urination	☐	☐	☐	

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Please check if you have any of these symptoms	YES	NO	N/A	Comments
GENITOURINARY (IF APPLICABLE)				
Testicular Pain	☐	☐	☐	
Impotence	☐	☐	☐	
Pain During Sex	☐	☐	☐	
Genital Sores	☐	☐	☐	
Abnormal Bleeding/Vaginal Discharge	☐	☐	☐	
Painful Periods	☐	☐	☐	
Premenstrual Syndrome (PMS)	☐	☐	☐	
MUSCULOSKELETAL				
Muscle Weakness	☐	☐	☐	
Muscle or Joint Pain	☐	☐	☐	
SKIN				
Rash	☐	☐	☐	
Moles (Growth or Changes)	☐	☐	☐	
NEUROLOGICAL				
Dizziness	☐	☐	☐	
Frequent Headaches	☐	☐	☐	
Seizures	☐	☐	☐	
Numbness	☐	☐	☐	
Memory Problems	☐	☐	☐	
PSYCHIATRIC				
Depression or Frequent Crying	☐	☐	☐	
Anxiety	☐	☐	☐	
Frequent Mood Changes	☐	☐	☐	
Panic Attacks	☐	☐	☐	

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Please check if you have any of these symptoms	YES	NO	N/A	Comments
ENDOCRINE				
Hair Loss	☐	☐	☐	
Heat/Cold Intolerance	☐	☐	☐	
Abnormal Thirst	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
Frequent Bruises	☐	☐	☐	
Enlarged Lymph Nodes "Glands"	☐	☐	☐	
Excessive Bleeding	☐	☐	☐	

Care Team

Names of other Healthcare Providers you currently see and why.

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____