RWJBarnabas HEALTH

Patient Name: _____DOB: _____Today's Date:_____

Past Medical History

Medical Problems/Diagnoses	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? ☐ Declined ☐	

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			

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

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?

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	☐	☐	☐	
GASTROINTENSTINAL				
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	☐	☐	☐	
GENITOURINARY (IF APPLICABLE)				
Abnormal Bleeding /Vaginal Discharge	☐	☐	☐	
Painful Periods	☐	☐	☐	
Premenstrual Syndrome (PMS)	☐	☐	☐	
Pain During Sex	☐	☐	☐	
MUSCULOSKELETAL				
Muscle Weakness	☐	☐	☐	
Muscle or Joint Pain	☐	☐	☐	
SKIN				
Rash	☐	☐	☐	
Moles (Growth or Changes)	☐	☐	☐	
NEUROLOGIC				
Dizziness	☐	☐	☐	
Frequent Headaches				
Seizures	☐	☐	☐	
Numbness	☐	☐	☐	
Memory Problems	☐	☐	☐	
PSYCHIATRIC				
Depression or Frequent Crying	☐	☐	☐	
Anxiety	☐	☐	☐	
Frequent Mood Changes	☐	☐	☐	
Panic Attacks	☐	☐	☐	
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: _____