



| <p>Past Surgical History</p> <p>Operations (with dates): _____</p> <p>_____</p> <p>_____</p> | <p>Hospitalizations Other than for Surgery</p> <p>_____</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------|---------------------|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--|
| <p>Other Physicians Currently Treating You</p> <p>Who, Where, Phone number, for What?</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>Allergies to medications, x-ray, dyes or other substances <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list name of medicine and type of reaction: _____</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Current Medications (Prescription, Vitamins, Herbs, Over-the-Counter, etc.)</p> <table border="0"> <thead> <tr> <th data-bbox="211 819 552 850">Drug Name</th> <th data-bbox="552 819 844 850">Dose (# times per day)</th> <th data-bbox="860 819 1088 850">For What?</th> <th data-bbox="1088 819 1372 850">Prescribed by Whom?</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> | Drug Name | Dose (# times per day) | For What? | Prescribed by Whom? | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | |
| Drug Name | Dose (# times per day) | For What? | Prescribed by Whom? | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | |
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| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | |
| <p>Family History</p> <p>Has any member of your family (including parents, grandparents and siblings) ever had any of the following:</p> <p><input type="checkbox"/> Cancer (describe type) _____</p> <p><input type="checkbox"/> Hypertension (high blood pressure) _____</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Strokes</p> <p><input type="checkbox"/> Mental Disease (Anxiety, Depression, etc.)</p> <p><input type="checkbox"/> Drug or Alcohol Addiction</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Bleeding Diseases</p> <p><input type="checkbox"/> Seizure Disorder</p> <p><input type="checkbox"/> Skin Problems</p> <p><input type="checkbox"/> Other: _____</p> | <p>Which family members?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Prevention/Social History</p> <p>Your Marital Status: _____</p> <p>Family members living in your home (Names/Relationship):</p> <p>_____</p> <p>_____</p> | <p>Have you ever worked with chemicals, paints, asbestos or hazardous material? _____</p> <p>(if yes, explain): _____</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | |



Underwood-Memorial Hospital's Family Medicine Center
Woodbury, NJ 08096

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| <p>Family members not living in your home (Names/Relationship): _____</p> <p>Your diet? _____</p> <p>Do you smoke (ever smoked)? _____ (if yes, how many packs per day)? _____ (if yes, for how many years)? _____ (if yes, are you interested in quitting)? _____ (if yes, have you ever tried to quit)? _____</p> <p>Do you drink alcoholic beverages? _____ (if yes, what kind, how much per week, for how many years)? _____ (if yes, are you interested in quitting)? _____ (if yes, have you ever tried to quit)? _____</p> <p>Do you drink coffee/tea? _____ (if yes, how many cups per day)? _____</p> <p>Do you use/ever used drugs? (marijuana, cocaine, crack, IV drugs, etc.)? _____</p> <p>When was your last:</p> <table style="width:100%; border: none;"> <tr> <td>Pap Smear _____</td> <td>Ever Abnormal? _____</td> </tr> <tr> <td>Breast Exam _____</td> <td>Ever Abnormal? _____</td> </tr> <tr> <td>Mammogram _____</td> <td>Ever Abnormal? _____</td> </tr> <tr> <td>Cholesterol Check _____</td> <td>Ever Abnormal? _____</td> </tr> <tr> <td>Stool Check _____</td> <td>Ever Abnormal? _____</td> </tr> <tr> <td>Prostate Exam _____</td> <td>Ever Abnormal? _____</td> </tr> </table> | Pap Smear _____ | Ever Abnormal? _____ | Breast Exam _____ | Ever Abnormal? _____ | Mammogram _____ | Ever Abnormal? _____ | Cholesterol Check _____ | Ever Abnormal? _____ | Stool Check _____ | Ever Abnormal? _____ | Prostate Exam _____ | Ever Abnormal? _____ | <p>Your recreation/hobbies: _____</p> <p>Do you always wear a seatbelt? _____</p> <p>Do you always wear a bike helmet? _____</p> <p>Do you exercise regularly? _____ (if yes, type, duration and # of times per week): _____</p> <p>Is there a gun in your home? _____</p> <p>Sexual partners (current and/or past): <input type="checkbox"/> Male Only <input type="checkbox"/> Female Only <input type="checkbox"/> Both</p> <p>Are you sexually active now? _____ (if yes, method of contraception): _____</p> <p>Have you ever been engaged in any activity which has put you are risk of getting AIDS? _____</p> <p>Are you in a relationship which you have been physically hurt (slapped, kicked, punched, bruised)? _____</p> <p>Do you ever feel afraid of being hurt by someone? _____</p> <p>Do you have a living will? _____</p> <p>Do you have an organ donor card? _____</p> |
| Pap Smear _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| Breast Exam _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| Mammogram _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| Cholesterol Check _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| Stool Check _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| Prostate Exam _____ | Ever Abnormal? _____ | | | | | | | | | | | | |
| <p>Immunization History</p> <p>Have you had any of these immunizations?</p> <p>Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Tetanus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Lymexix <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Pneumovax <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Flu <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure When? _____</p> <p>Other _____</p> | | | | | | | | | | | | | |

This information is for use by your physician as part of your confidential medical record.

Patient's Signature

Physician's Signature