Barnabas Health

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)

Anemia		Cataracts		Glaucoma		Kidney Disease		Rheumatic Fever	
Angina		Chicken Pox		Heart Attack		Kidney Stones		Seizure/Epilepsy	
Arthritis		Dementia		Heart Disease		Lung Disease		Sleep Apnea	
Asthma		Depression / Anxiety		Heart Murmur		Measles		Stomach Ulcers	
Bleeding Disorder		Diabetes		Hemorrhoids		Migraines/ Headaches		Stroke	
Blood Clots (DVT/PE)		Digestive Disorders		High Blood Pressure		Pneumonia		Thyroid Disease	
Blood Transfusion		Frequent Infections		High Cholesterol		Pre-Diabetes		Tuberculosis	
Cancer		type of cancer:		Jaundice or Liver Disease		Prostate Enlargement		Other:	

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)				

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

	Never	Past	Current	Amount
Tobacco Use				
Alcohol Use				
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**		

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?

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