Barnabas Health Medical Group | RWJBarnabas HEALTH

Practice location info here

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

Name: ________________________________ Date of Birth: ____/____/________

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

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

| | Never | Past | Current | Amount |
|---|---|---|---|---|
| **Tobacco Use** | | | | |
| **Alcohol Use** | | | | |
| **Seat Belt Use** | | | | |
| | | | | |

Name: ________________________________ Date of Birth: ____/____/_________

| 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 | | | |
| | | | |
| | | | |

Name: ________________________________ Date of Birth: ____/____/________

| 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 | | |
| Others | | |

6146-10/16