HUNTERDON HEALTHCARE PARTNERS

PATIENT INFORMATION FORM

DATE:

PATIENT NAME:

Age: Birthdate: Date of last physical exam:

What is reason for visit?

FAMILY HISTORY:

Father: Alive: ☐ Deceased: ☐ Present health or cause of death

Mother: Alive: ☐ Deceased: ☐ Present health or cause of death

Brothers: # Alive: Health:

Deceased: Cause of Death:

Sisters: # Alive: Health:

Deceased: Cause of Death:

Children: # Alive: Sex, ages and health:

Deceased: Cause of Death:

Check illnesses which have occurred in any of your blood relatives:

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Heart disease ☐ Stroke ☐ High Blood Pressure ☐ Allergies

☐ Other

SYMPTOMS: Check conditions you currently have or have had in the past year.

General

☐ Chills
☐ Depression/Nervousness
☐ Dizziness
☐ Fatigue
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of weight

Gastrointestinal

☐ Appetite Poor
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion

Eye,Ear,Nose,Throat

☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing

Men Only

☐ Breast lump
☐ Erection difficulties
☐ Lump in testicles
☐ Penis discharge
☐ Sore on penis
☐ Other

Women Only

☐ Abnormal Pap
☐ Irg. Bleeding

- [ ] Numbness
- [ ] Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Hips
- [ ] Back
- [ ] Legs
- [ ] Feet
- [ ] Neck
- [ ] Hands
- [ ] Shoulders

Genito-Urinary

- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

Cardiovascular

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Varicose veins

- [ ] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision-Flashes/Halos

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sores that won't heal

- [ ] Breast Lump
- [ ] Menstrual Pain
- [ ] Hot Flashes
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other

Last menstrual period? ________

Last PapSmear? ________

Last Mammogram? ________

Are you pregnant? ________

Conditions: Check conditions you currently **have or have had in the past**

- [ ] Aids
- [ ] Alcoholism
- [ ] Anorexia
- [ ] Appendicitis
- [ ] Arthritis
- [ ] Bleeding disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Cataracts
- [ ] High Cholesterol
- [ ] HIV Positive
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Measles
- [ ] Migraine Headaches
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Multiple Sclerosis
- [ ] Mumps
- [ ] Pacemaker

- [ ] Chemical Dependency
- [ ] Chicken Pox
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart Disease
- [ ] Hernia
- [ ] Herpes
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate Problem
- [ ] Psychiatric Care
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Stroke
- [ ] Suicide Attempt
- [ ] Thyroid problems
- [ ] Ulcers
- [ ] Vaginal Infections
- [ ] Venereal Disease

Medications/Allergies:

List current medications you are taking: ______

Are you taking any herbal supplements? ______ Please list supplements: ______

Are you taking any vitamins? ______ Please list vitamins: ______

List allergies to medications and substances: ______

Health Habits: Check what substance you use and how much.

- [ ] Caffeine
- [ ] Tobacco
- [ ] Drugs ______

Check if your work exposes you to the following:

- [ ] Stress
- [ ] Heaving Lifting
- [ ] Other ______

☐ Hazardous Substances

Your Occupation: ☐

Signatures:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I made in the completion of this form.

Signature: ____Date: ☐

Reviewed by:
____Date:____