SeretisCare Family Practice

George Seretis, D.O.
The Health Center at Beckett 499 Beckett Road, Suite 201, Logan Township, NJ 08085
(856) 467-6400 F: (856) 467-1033

Patient Health History Form

Welcome to our practice! As a new patient, please fill out the information below to the best of your ability.

NAME: _____ DOB: ___/___/___ DATE: ___/___/___

HOME # _____ CELL #_____ E-MAIL:_____

REASON for VISIT: _____ Prior Dr's Name:_____

PAST MEDICAL HISTORY: Have you ever had or currently have any of the following: (circle):

AIDS or HIV	Cancer (Type):	Erectile Dysfunction	Lupus
Alcohol or Drug Abuse	Chickenpox	Glaucoma	Meningitis
Anemia	Congestive Hrt Failure	Gout	Migraines
Arthritis	Chemotherapy	Heart Disease	Osteoporosis / Osteopenia
Asthma	Colitis (Type):	Hepatitis (Type):	Parkinson's Disease
Back Pain (Chronic)	COPD	High Blood Pressure	Reflux Disease / GERD
Bipolar Disease	Dementia	High Cholesterol	Seizure / Epilepsy
Bleeding Disorders	Depression	IBS	Stroke & Year:
Blood Transfusion(s)	Diabetes & Year Diagnosed:	Incontinence	STD (Type):
BPH (enlarged prostate)	Diverticulitis	Kidney Disease or Stones	Thyroid (Hypo / Hyper / Nodules)

OTHER MEDICAL CONDITIONS *NOT* LISTED ABOVE:

REVIEW of SYMPTOMS: Please describe any symptoms you have or may be presently experiencing or concerning to you:

LIST YOUR CURRENT MEDICATIONS & DOSAGES:

ALLERGIES TO MEDICATIONS or DYES & REACTION(S): Y / N (list below):

PREVIOUS SURGERIES & DATES:

GYNECOLOGIC & OBSTETRIC HISTORY: OB/GYN' NAME: _____

Age at onset of periods: _____ First Day of Last Menstrual Period: ____/____/_____

# of Pregnancies: _____ # of Full Term Births: _____ # of Premature Births: _____

# of Miscarriages: _____ # of Abortions: _____ # of Children living: _____

Have you had a Hysterectomy: Partial or Total; When Year: ____/____/_____

Have you had a history of any Abnormal Pap Smears or Mammograms: Y / N *** If Yes Please Describe:

_____

IMMUNIZATION HISTORY: (Have you been immunized to): circle Y or N & Year Administered:

Hepatitis B: Y / N _____ **Pneumonia Vaccine:** Y / N _____ **Tetanus:** Y / N _____

SOCIAL HISTORY:

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Alcohol Use: None _____ Rare _____ Social _____ Daily _____ History of Abuse _____
If you abused or were dependent on Alcohol what year did you Quit:_____

Tobacco Use: If you Currently Smoke what do you smoke: Cigarettes _____ Cigars _____ Chew _____
How Many Packs/day _____ How Many Years Have you been Smoking: _____

If you Quit Smoking, What Year_____ How many Packs/day _____ How many Years _____

Drug Use: Never _____ Rare _____ Daily _____ Type of Drugs: _____
Are you still using Drugs: Y / N

OCCUPATION: (are you employed & type of job) _____

DISABLED: (if you are disabled list why & when) _____

EDUCATION: (Level & Names of Higher level Schools) _____

FAMILY HISTORY: (Please tell us about your parents, siblings & children):

MEMBER:	**AGE:**	**Living Y/N:**	**MEDICAL HISTORIES:**
Father			
Mother			
Siblings # _____			
Children # _____			

To the best of my knowledge, the information on this form is accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and his staff of any changes in my medical status. I also authorize the staff to perform the necessary services I may need. Please sign below. If you are signing for a minor, please state your relationship after your signature.

_____ _____

PATIENT or GUARDIAN'S SIGNATURE **DATE**