SeretisCare Family Practice

The Health Center at Beckett 499 Beckett Road, Suite 201-B Logan Township, NJ 08085

P: (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:** _____

REASON for VISIT: _____ **Prior Drs Name:** _____

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

AIDS or HIV	Cancer: _____	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	Strokes: Type _____
Blood Transfusion(s)	Diabetes: Type _____	Incontinence	STD: Type _____
BPH (enlarged prostate)	Diverticular Disease	Kidney Disease / Stones	Thyroid Disease

OTHER MEDICAL CONDITIONS *NOT* LISTED ABOVE:

_____

_____

REVIEW of SYMPTOMS: Please Circle if you are presently experiencing any of the following:

Recent Weight Loss	Facial Pain	Change in BMs	Joint Pain
Recent Weight Gain	Swollen Glands	Nausea &/or Vomiting	Numbness – Extremities
Loss of Height	Chest Pain or Pressure	Diarrhea or Constipation	Tingles – Extremities
Fevers	Chest Tightness	Rectal Bleeding	Back Pain
Chills	Palpitations	Abdominal Pain	Neck Pain
Hot Flushes	Leg Edema or Swelling	Urinary Frequency	Muscle Weakness
Night Sweats	Wheezing	Urinary Urgency	Muscle Cramps
Fatigue	Cough: Dry or Wet	Urinary Hesitancy	Rash
Headaches	Shortness of Breath	Burning with Urination	Dizzy or Light Headed
Head Congestion	Fainting or Passed Out	Blood in Urine	Tremors
Crusty eyes	Spitting up Blood	Urinary Dribbling	Nervousness
Eye Redness	Trouble Swallowing	Dec'd Urine Stream	Depression
Eyelid Swelling	Fever Blisters	Incontinence of Urine	Suicidal Thoughts
Clogged Ears	Laryngitis	Sexual Difficulty	Insomnia
Earache	Snoring	Painful Periods	Memory Loss
Nose Bleeds	Daytime Sleepiness	Vaginal D/C or Bleed	Excessive Thirst
Sore Throat	Heartburn	Breast Mass or Lump	Excessive Urination
Sinus Pressure	Dec'd Appetite	Nipple D/C or Bleed	Hear or Cold Intolerance

CURRENT MEDICATIONS:

_____

_____

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

_____

PREVIOUS SURGERIES:

_____

_____

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 : What: _____

IMMUNIZATION HISTORY: (Have you been immunized to): circle Y or N & place year

Hepatitis B: Y / N _____ Pneumonia Vaccine: Y / N _____ Tetanus: Y / N – year: _____

SOCIAL HISTORY:

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Alcohol Use: None ____ Rare ____ Social _____ Daily _____ Abuse _____ Quit (year) _____
Tobacco Use: Never ____ Current ____ *TYPE:* Cigarettes _____ Cigars _____ Chew _____
Packs/day _____ for how many Years _____
If you Quit Smoking ____ What Year _____ # Packs/day _____ # of Years _____
Drug Use: Never ___ Rare ___ Daily ___ Abuse ___ Quit (year) _____ Type _____

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

DISABLED: (if you are permanently 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**

REVIEWED with the Patient: the above information has been reviewed by: