



History Form

(Must be completed for all initial visits or yearly)

NAME: _____

Date: ____ / ____ / ____

Past Hospitalization or Surgery Reason	Date	Reason	Date

Women Only Pregnant? YES NO Planning Pregnancy? YES NO

General History

Have you ever had?	Yes	No
1. Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
2. Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
3. Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
4. Mental, brain, nervous trouble	<input type="checkbox"/>	<input type="checkbox"/>
5. Fits, epilepsy, convulsions	<input type="checkbox"/>	<input type="checkbox"/>
6. Lung disease or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma, hay fever, sinus	<input type="checkbox"/>	<input type="checkbox"/>
8. Blindness, color blindness	<input type="checkbox"/>	<input type="checkbox"/>
9. Ear trouble, decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>
10. Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes, frequent boils	<input type="checkbox"/>	<input type="checkbox"/>
12. Tuberculosis, splitting of blood	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
14. Chest pains / discomfort	<input type="checkbox"/>	<input type="checkbox"/>
15. Coughing or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
16. Heart trouble/heart attack/stroke	<input type="checkbox"/>	<input type="checkbox"/>
17. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
18. Stomach trouble, ulcers	<input type="checkbox"/>	<input type="checkbox"/>
19. Thinking or sleeping troubles	<input type="checkbox"/>	<input type="checkbox"/>
20. Gall bladder or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
21. Yellow jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
22. Blood in stool or urine	<input type="checkbox"/>	<input type="checkbox"/>
23. Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
24. Skin disease or rash	<input type="checkbox"/>	<input type="checkbox"/>
25. Kidney trouble/stones	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had?	Yes	No
26. Rupture of hernia	<input type="checkbox"/>	<input type="checkbox"/>
27. Varicose veins, leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>
28. Rheumatism, arthritis, gout	<input type="checkbox"/>	<input type="checkbox"/>
29. Deformity, amputations	<input type="checkbox"/>	<input type="checkbox"/>
30. Stiff joints, trick shouders/ knees	<input type="checkbox"/>	<input type="checkbox"/>
31. Back trouble	<input type="checkbox"/>	<input type="checkbox"/>
32. Scars, identifying marks	<input type="checkbox"/>	<input type="checkbox"/>
33. Cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>
34. Blood disease or anemia	<input type="checkbox"/>	<input type="checkbox"/>
35. Military service	<input type="checkbox"/>	<input type="checkbox"/>
36. Rejected for military service	<input type="checkbox"/>	<input type="checkbox"/>
37. Eye trouble, vision problem(s)	<input type="checkbox"/>	<input type="checkbox"/>
38. Unusual weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
39. Are glasses adequate?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever x-rayed? When ____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
41. Seen a doctor in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
42. Ever rejected for life insurance?	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you ever been rejected for employment for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
44. Serious infections	<input type="checkbox"/>	<input type="checkbox"/>
45. Urine problem	<input type="checkbox"/>	<input type="checkbox"/>
46. Thyroid, gland disease	<input type="checkbox"/>	<input type="checkbox"/>
47. Any relative with (TB,diabetes,cancer)	<input type="checkbox"/>	<input type="checkbox"/>
48. Ever seen a counselor, psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
49. Tuberculin test	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much? _____		
If yes, how often? _____		

Are you unable to perform certain motions, assume positions or lift heavy objects? _____ YES _____ NO

Exercise Routine: _____

Remarks (Indicate item # & year) _____

Reviewed by _____

MD Signature

- Care Station 1
- Care Station 2
- Care Station 3
- Care Station 4

328 W. St. Georges Avenue, Linden NJ 07036
 90 Route 22 West, Springfield, NJ 07081
 456 Prospect Avenue, West Orange, NJ 07052
 210 Meadowlands Parkway, Secaucus, NJ 07094

908-925-2273
 973-467-2273
 973-731-6767
 201-348-3636

Name: _____

Date: ____ / ____ / ____

Family History: Fill in completely for living and dead relatives

Relation	Age if living	Age at death	Cause of Death (if known)	a*	Diabetes	Heart Attack	High Blood Pressure	Stroke	Kidney Disease	Tuberculosis	Cancer	Liver Disease	Epilepsy	Allergy	Asthma	Glaucoma	Psychiatric Illness	Alcoholism	Specify** If Other	
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Father																				
Mother																				
Husband/Wife (name)																				
Children (names)																				

GENITOURINARY TRACT	Yes	No		
WOMEN				
Breast problems or breast surgery			Age at first menstrual period	
Abnormal mammogram			Date of last menstrual period	
Abnormal pap smear			Date of period before that	
Vaginal discharge			Usual time from beginning or menstrual period to beginning of next in days	
Irregular periods or spotting			Please indicate following numbers:	
Recurrent vaginal area rash or discomfort at time of periods				Pregnancies (total number)
Pain with intercourse				Deliveries (Live and stillborn)
Bleeding with intercourse				Premature deliveries
CONTRACEPTION (Birth Control Methods)				Miscarriages
Tubal Ligation				Abortions
Condoms and/or foam				Cesarean sections
Birth control pills				Living children
IUD (loop, spring, copper7 or T, etc.				Other surgical procedures dealing with pregnancy
Diaphragm				
Any other method of contraception				
Are you pregnant now?				