HEALTH CONSULTANTS OF NORTH JERSEY

Past Medical History Form

Patient Name_____ **Age** _____ **Date** _____

WHAT IS THE REASON YOU ARE SEEING THE DOCTOR TODAY?

_____

MEDICATION ALLERGIES _____ **No** Known Allergies
Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____

LIST ALL SURGERIES _____
_____
_____

CURRENT LIST OF MEDICATIONS (include dose, reason you take it, who prescribed it)
Medication Dose Quantity Frequency Use

_____
_____
_____
_____

CURRENT LIST OF OVER THE COUNTER MEDICATIONS (vitamins and food supplements)

_____
_____

Which of the following conditions are you currently being treated or have been treated for in the past? (Please check the box)

- ☐ Heart disease/murmur/angina
- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Heartburn/ reflux
- ☐ Anemia/blood or bleeding problems
- ☐ Swollen ankles/vein problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problem
- ☐ Corrective lenses/glasses
- ☐ Hernia
- ☐ COPD
- ☐ Asthma
- ☐ Lung problems/cough
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Tonsillitis
- ☐ Ear Problems
- ☐ Kidney/bladder problem
- ☐ Cancer
- ☐ Sexually transmitted disease
- ☐ Hearing loss
- ☐ Kidney stones
- ☐ Eye disorder/glaucoma
- ☐ Seizures
- ☐ Stroke
- ☐ Headaches/migraine
- ☐ Neurological problems
- ☐ Depression/anxiety
- ☐ Psychiatric care
- ☐ Liver problem/hepatitis
- ☐ Ulcers/colitis
- ☐ Prostate problems
- ☐ Rheumatic fever
- ☐ Eating disorder

Please describe any current or past medical treatment not listed above

_____

ADULT IMMUNIZATIONS Approximate date of last, or provide copy of immunization record
Tetanus (Td or TdaP) _____ Zoster (Shingles) _____
Pneumonia _____ HPV _____
Influenza (flu) _____
Last TB screening _____
Have you been tested or vaccinated for hepatitis A, B, or C? ☐ Yes ☐ No

Have you ever been hospitalized overnight? ☐ Yes ☐ No If yes, give reason, when and where:

_____
_____

Females: History

How many times have you been pregnant? _____ Date of last Pap Smear _____

List of all Family Medical History (Including parents and siblings)

_____
_____
_____