

## HEALTH CONSULTANTS OF NORTH JERSEY

## **Past Medical History Form**

Have you ever been hospitalized overnight?   Yes   No If yes, give reason, when and where:  Females: History	Patient Name	Age	Date	
Allergy Reaction   Aller disease   Alle	WHAT IS THE REASON YOU ARE SEEING	THE DOCTOR	ODAY?	
Allergy			LIST ALL SU	IRGERIES
CURRENT LIST OF MEDICATIONS (include dose, reason you take it, who prescribed it)  Medication	Allergy Reaction			
CURRENT LIST OF MEDICATIONS (include dose, reason you take it, who prescribed it)  Medication	Allergy Reaction			
CURRENT LIST OF MEDICATIONS (include dose, reason you take it, who prescribed it) Medication	Allergy Reaction			
CURRENT LIST OF OVER THE COUNTER MEDICATIONS (vitamins and food supplements)	Allergy Reaction			
Which of the following conditions are you currently being treated or have been treated for in the past? (Plecheck the box)    Heart disease/murmur/angina				
Heart disease/murmur/angina	CURRENT LIST OF OVER THE COUNTER	MEDICATIONS (	vitamins and food s	supplements)
High cholesterol	check the box)			
□ Low blood pressure □ Lung problems/cough □ Stroke □ High blood pressure □ Sinus problems □ Heardaches/migraine □ Heartburn/ reflux □ Seasonal allergies □ Neurological problems □ Depression/anxiety □ Diabetes □ Prostate problem/hepatitis □ Cancer □ Ulcers/colitis □ Depression/anxiety □ Diabetes	•			
☐ High blood pressure       Sinus problems       Headaches/migraine         ☐ Heartburn/ reflux       Seasonal allergies       Neurological problems         ☐ Anemia/blood or bleeding problems       Tonsillitis       Depression/anxiety         ☐ Swollen ankles/vein problems       Ear Problems       Psychiatric care         ☐ Diabetes       Kidney/bladder problem       Liver problem/hepatitis         ☐ Arthritis       Cancer       Ulcers/coltitis         ☐ Thyroid Problem       Sexually transmitted disease       Prostate problems         ☐ Corrective lenses/glasses       Hearing loss       Rheumatic fever         ☐ Hernia       Kidney stones       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)       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				
High blood pressure		<ul><li>Lung prob</li></ul>	lems/cough	□ Stroke
☐ Heartburn/ reflux       ☐ Seasonal allergies       ☐ Neurological problems         ☐ Anemia/blood or bleeding problems       ☐ Tonsillitis       ☐ Depression/anxiety         ☐ Swollen ankles/vein problems       ☐ Ear Problems       ☐ Psychiatric care         ☐ Diabetes       ☐ Kidney/bladder problem       ☐ Liver problem/hepatitis         ☐ Arthritis       ☐ Cancer       ☐ Ulcers/colitis         ☐ Thyroid Problem       ☐ Sexually transmitted disease       ☐ Prostate problems         ☐ Corrective lenses/glasses       ☐ Hearing loss       ☐ Rheumatic fever         ☐ Hernia       ☐ Kidney stones       ☐ 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)       ☐ Provide and the provide action of t	□ High blood pressure	<ul><li>Sinus prol</li></ul>	olems	☐ Headaches/migraine
Swollen ankles/vein problems	☐ Heartburn/ reflux	Seasonal	allergies	□ Neurological problems
Swollen ankles/vein problems	☐ Anemia/blood or bleeding problems	□ Tonsillitis	-	
□ Diabetes □ Kidney/bladder problem □ Liver problem/hepatitis □ Cancer □ Ulcers/colitis □ Thyroid Problem □ Sexually transmitted disease □ Prostate problems □ Corrective lenses/glasses □ Hearing loss □ 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 □ If yes, give reason, when and where: □ Females: History □ Date of last Pap Smear □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		□ Ear Proble	ems	
Arthritis	•	□ Kidnev/bla	adder problem	
Thyroid Problem				
Corrective lenses/glasses				
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?				
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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?				
Have you been tested or vaccinated for hepatitis A, B, or C?	Tetanus (Td or TdaP) Zos Pneumonia HP\ Influenza (flu)	ter (Shingles)	e copy of immunizat	tion record
Have you ever been hospitalized overnight?	Have you been tested or vaccinated for hepa	atitis A, B, or C?	□ Yes □ No	
Females: History  How many times have you been pregnant? Date of last Pap Smear				ason, when and where:
How many times have you been pregnant? Date of last Pap Smear	J		, , , , , , , , , , , , , , , , , , ,	
	Females: History			
List of all Family Medical History (Including parents and siblings)	How many times have you been pregnant?		Date of last Pap	Smear
	List of all Family Medical History (Inclu-	ding parents and	d siblings)	
	List of an i anning medical instory (inclu	anig parents and	a olbinigo,	