Sea Girt Medical Associates
Health History Form

Today's Date: _____ Preferred Language: _____

Name: _____ Date of Birth: _____

Email address: _____ Home Phone: _____

Local Pharmacy: _____ City: _____ Cell Phone: _____

Mail Away Pharmacy: _____ Work Phone: _____

Do you have a living will? ☐ No ☐ Yes Are you hearing or visually impaired? (Circle): **Hearing Visual**

Please list all current medications (including supplements/over-the-counter), dose, and frequency (e.g. lipitor, 20 mg, 2/day, melatonin 3mg 1/day, etc):

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Please list all medical problems you have been diagnosed with (e.g. diabetes, hypertension, depression):

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Please list any surgeries you've had and the year the surgery was done (e.g. tonsils, 2003):

1. _____ 3. _____ 6. _____
2. _____ 4. _____ 7. _____

Have you been hospitalized in the last year? ☐ No ☐ Yes – explain: _____

_____

Allergies

Do you have any drug or other allergies? ☐ No ☐ Yes – to what? _____

Social History

What is your occupation? (If retired, please state former occupation)_____

Where do you work? _____Who do you live with? _____

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

Exercise ☐ No ☐ Yes ☐ Aerobics ☐ Weights # days/week _____ Duration _____ min

Drug Use ☐ Never ☐ Yes (Please explain): _____

Alcohol Use ☐ None ☐ In recovery since: _____ ☐ Yes -– Drinks per week: _____

Tobacco Use* ☐ Never ☐ Current ☐ Quit – when?_____

***If you currently smoke, are you interested in quitting?** ☐No ☐ Yes

Health Maintenance – Please write date of last:

	Recommendation *(may vary depending on age/risk factors)*	**Date**	**Performing physician and/or facility:**	**Check if none:**
Colonoscopy	Every 5-10 years for **everyone** age 50+			☐
PSA	Yearly for **men** age 50+			☐
Mammogram	Yearly for all **women** age 40+			☐
Pap smear	Yearly for all **women** age 21+			☐
Bone density scan	Every 2 years for postmenopausal **women**			☐

Immunization History:

Influenza	Yearly for **everyone** age 50+			☐
Pneumonia	**Everyone** age 65+, earlier w/ certain illnesses			☐
Shingles	Indicated for **everyone** age 50+			☐
Tetanus				☐

Patient Name:_____ **Date:**_____

Family History

Please list immediate family health problems **(limited to parents, siblings, and children)**. Include current age or age at death and health/mental problems, such as cancers, hypertension, stroke, diabetes, cholesterol, osteoporosis, depression, substance abuse disorder, etc.

Relative	Alive	Deceased	Age or Age at Death	Health/Mental Problems
Mother	☐	☐		
Father	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
Brother/Sister	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		
_____	☐	☐		

Does your *family have a history of:**
**Limited to parents, siblings, and children*

			Family member(s):
Breast cancer	☐ No	☐ Yes	_____
Colon cancer or polyps	☐ No	☐ Yes	_____
Gynecological cancer	☐ No	☐ Yes	_____
Prostate cancer	☐ No	☐ Yes	_____
Skin cancer	☐ No	☐ Yes	_____

Patients with diabetes, please complete:

Name of endocrinologist: _____
Date of last visit: _____
Name of podiatrist: _____
Date of last visit: _____
Name of ophthalmologist: _____
Date of last visit: _____

Do you have any of the following symptoms?

- ☐ Bee sting allergy
- ☐ Latex allergy
- ☐ Reoccuring fevers
- ☐ Unexplained weight loss
- ☐ Change in skin color
- ☐ New or changing skin spots
- ☐ Non-healing sores
- ☐ Obstructed swallowing
- ☐ Change in voice
- ☐ Recent change in vision
- ☐ Recent change in hearing
- ☐ Neck mass
- ☐ Lymph gland swelling
- ☐ Chronic cough
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Ankle swelling
- ☐ Exertional chest pain
- ☐ Palpitations
- ☐ Heartburn
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Blood in your stool
- ☐ Black or tarry stools
- ☐ Lactose intolerance
- ☐ Incontinence
- ☐ Erectile dysfunction
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Abnormal menstruation
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Broken bones
- ☐ Dizziness
- ☐ Slurred speech
- ☐ Anxiety
- ☐ Depression
- ☐ Previous psychiatric care
- ☐ Suicidal thoughts
- ☐ History of trauma
- ☐ Change in height
- ☐ Hot or cold intolerance
- ☐ Reoccuring nose bleeds

☐ **Please check, if none of the above.**

Please explain any **positive** responses:

_____
_____
_____
_____
_____
_____