

HUDSON COUNTY PRIMARY CARE
MEDICAL HISTORY FORM ♦ PLEASE PRINT CLEARLY

PATIENT'S NAME: _____

AGE: _____ **DATE OF YOUR LAST PHYSICAL EXAM:** _____

PAST MEDICAL HISTORY:

Anxiety/Depression Yes ____ No ____
Arthritis Yes ____ No ____
Asthma Yes ____ No ____
Blood Pressure Yes ____ No ____
Cancer _____ Yes ____ No ____
Cholesterol Yes ____ No ____
COPD/Emphysema Yes ____ No ____
Diabetes Mellitus Yes ____ No ____
Heart Disease/Arrhythmia Yes ____ No ____
Hepatitis __ A __ B __ C Yes ____ No ____
HIV/AIDS Yes ____ No ____
Stroke Yes ____ No ____
Ulcer/Gastritis Yes ____ No ____
Other _____

PAST SURGICAL HISTORY:

MEDICATIONS AND DOSAGES:

PREVIOUS HOSPITALIZATIONS:

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ALLERGIES:

Medications _____

Environmental _____

Food _____

FAMILY HISTORY:

Cancer Yes ____ No ____ if yes, who _____

Cholesterol Yes ____ No ____ if yes, who _____

Diabetes Yes ____ No ____ if yes, who _____

Heart disease Yes ____ No ____ if yes, who _____

Hypertension Yes ____ No ____ if yes, who _____

Other _____

SOCIAL HISTORY:

What is your marital status? S ____ M ____ D ____ W ____

How many children do you have? _____

What is your occupation? _____

Do you smoke?....How much?....For how long? _____

Do you drink alcohol?....How much? _____

Do you use drugs? _____

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PREVENTIVE HEALTH CARE:

	<u>MEN</u>				<u>WOMEN</u>		
	Y	N	DATE		Y	N	DATE
Colonoscopy	-----	-----	-----	Colonoscopy	-----	-----	-----
PSA	-----	-----	-----	Bone density	-----	-----	-----
EKG	-----	-----	-----	Mammogram	-----	-----	-----
Stress test	-----	-----	-----	Pap smear	-----	-----	-----
Flu vaccine	-----	-----	-----	EKG	-----	-----	-----
Pneumonia vaccine	-----	-----	-----	Stress test	-----	-----	-----
Tetanus shot	-----	-----	-----	Flu vaccine	-----	-----	-----
				Pneumonia vaccine	-----	-----	-----
				Tetanus shot	-----	-----	-----

SIGNATURE: _____ **DATE:** _____