YOUR DOCTORS CARE
71 Route 206
Hillsborough, N.J. 08844
(908) 685-1887

NAME: **DOB:** **Today's Date:**

In the past three(3) months, have you been having any of the following? (CHECK ALL THAT APPLY)

Constitutional	Cardiovascular	Reproductive	Psychiatric	Hemo/Lymphatic
Chills	Chest pain	**MALE**	Anxiety	Easy bleeding
Fatigue	Edema	Erectile dysfunction	Depression	Easy bruising
Fever	Palpitations	Penile discharge	Insomnia	Swollen glands
Malase	Pain in the leg(s)	Sexual dysfunction	Other:	Other
Night Sweats	Other:	Other:		
Weight Gain				
Weight Loss		**FEMALE**	**Integumentary**	**Immunologic**
Other:	**Gastrointestinal**	LMP: ___/___/___	Brittle hair	Contact allergy
	Abdominal pain	Abnormal PAP	Brittle nails	Environmental allergies
HEENT	Blood in stools	Painful menses	Hair loss	Food allergies
Ear drainage	change in stools	Pain w/ intercourse	Unusual hair growth	Seasonal allergies
Ear pain	Constipation	Hot flashes	Hives	Other:
Eye discharge	Diarrhea	Irregular menses	Itchy skin	
Eye pain	Heartburn	Vaginal discharge	Mole changes	**Neurological**
Hearing loss	Loss of appetite	Other:	Rash	Dizziness
Nasal discharge	Nausea	**Metabolic/Endocrine**	Skin lesions	Numbness
Sinus pressure	Vomiting	Cold intolerance	Other:	Loss of strength
Sore throat	Other:	Heat intolerance	**Musculoskeletal**	Trouble walking
Visual changes		Excessive thirst	Back pain	Headaches
Other:	**Genitourinary**	Excessive hunger	Joint pain	Memory Loss
	Dribbling	Other:	Joint swelling	Seizures
Respiratory	Dificulty urinating		Muscle weakness	Tremors
Chronic cough	Blood in urine		Neck pain	Other:
cough	excessive urination		Other:	
Known TB exposure	slow stream			
Shortness of breath	Urinary frequency			
Wheezing	Urinary incontinence			
Other:	Urinary retention			
	Other			

Immunizations:

Flu- Date:		Pneumovax (Pneumonia Vac) Date:	
Tetanus- Date:		Other:	
Shingles vaccine- Date:		Other:	
Varicella (chicken pox) Date:		Other:	

Have you had any falls in the past year?	No	Yes How many?
Have you been seen in the Emergency room in the past year?	No	Yes How many times?

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Have you ever used tobacco?			☐ Never		☐ Current		☐ Former	
If current or former, what type(s)								
☐ Cigarette	☐ Cigarillo		☐ Cigar		☐ Pipe		☐ Snuff	
☐ Chewing	☐ Smokeless							
Years used:	Age started		Age stopped		☐ Use everyday		☐ Use sometimes	
Have you ever had pasive smoke exposure?					☐ Yes		☐ No	
Do you drink alcohol?					☐ Yes		☐ No	
Type of alcohol:	☐ Beer		☐ Liquor		☐ Wine		☐ Other	
Frequency	☐ Daily		☐ Weekly		☐ Monthly		☐ Yearly	
	☐ Occasionally		☐ Rarely		☐ Socially			
Do you drink/consume caffeine?					☐ Yes		☐ No	
Type of Caffeine	☐ Coffee		☐ Tea		☐ Soda		☐ Chocolate	
	☐ Energy Drinks							
On average how much caffeine is consumed per day?					Cups/amount			
What is your activity level?			☐ Sedentary		☐ Moderate		☐ Vigorous	
Are you a health club member?			☐ Now		☐ Previously		☐ Never	
Do you exercise?					☐ Yes		☐ No	
Type of exercise?								
Frequency of exercise?	☐ 2-3 times/week		☐ 3-4 times/week		☐ Daily		☐ occasional	
What is your marital status?			☐ Single		☐ Married		☐ Divorced	
	☐ Domestic Partner		Other:					
Do you have a religious affiliation?			☐ No		☐ Yes Religion:			
Are you legaly blind?					☐ Yes		☐ No	
Do you have permament hearing loss?					☐ Yes		☐ No	

Are there any medical condition that run in your immediate family? (Parents, Siblings, Grandparents, Aunts, Uncles.)

		Relationship			Relationship	
☐	ADD/ADHD		☐	Irritable Bowel		Other:(list below)
☐	Alcoholism		☐	Learning disability		
☐	Alzheimer's		☐	Mental illness		
☐	Arthritis		☐	migranes		
☐	Asthma		☐	obesity		
☐	Blood disorder		☐	osteoporosis		
☐	Cardiovascular Disease		☐	Vascular disease		
☐	Cholesterol		☐	Renal disease		
☐	Coronary Artery Disease		☐	seizure disorder		
☐	Depression		☐	Stroke		
☐	Developmental Delay		☐	Thyroid Disorder		
☐	Diabetes		☐	Cancer:		
☐	Hypertension			type		