

Patient Care Center of New Jersey

Patient Information

Date _____ Social Security # _____
Last Name _____ First Name _____ MI _____
Mailing Address _____ Apt # _____
City _____ State _____ ZipCode _____
Physical Address _____ Apt # _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____
Birthday _____ Sex _____ Race _____ Employer _____
Work Address _____ Work Phone _____

Marital Status	Student	Employment	Relationship to Insured
<input type="checkbox"/> Single	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full time	<input type="checkbox"/> Self
<input type="checkbox"/> Married	<input type="checkbox"/> Part-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Spouse
<input type="checkbox"/> Divorced	<input type="checkbox"/> None	<input type="checkbox"/> Not employed	<input type="checkbox"/> Child
<input type="checkbox"/> Separated		<input type="checkbox"/> Self employed	<input type="checkbox"/>
<input type="checkbox"/> Widowed		<input type="checkbox"/> Retired	Other _____

Primary Insurance _____ Secondary Insurance _____

Insured/Responsible Party

Relationship to patient _____ SS # _____
Last Name _____ First Name _____ MI _____
Mailing Address _____ Apt # _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____
Birthday _____ Sex _____ Race _____ Employer _____
Work Address _____ Work Phone _____

*****Please present your insurance card and valid picture ID to the receptionist.***

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient Care of New Jersey

PERSONAL HEALTH HISTORY

Name _____ Date _____

PAST MEDICAL HISTORY

High Blood Pressure [Y][N] Diabetes [Y][N] Heart Attack [Y][N]
Thyroid Disease [Y][N] Anemia [Y][N] Heart Disease [Y][N]
High Cholesterol [Y][N] Asthma [Y][N] Depression [Y][N]
Hospitalization [Y][N] Why _____
Other Illness [Y][N] List _____

PAST SURGERY

Appendix [Y][N] Other Surgeries [Y][N]
Tonsils [Y][N] _____
C-Section [Y][N] _____
Gallbladder [Y][N] _____
Hysterectomy [Y][N] _____

CURRENT MEDICATIONS

Medication Name	Dose	When Taken	Refills Needed
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]

Medication Allergies [Y][N] _____

FAMILY HISTORY

Heart Disease [Y][N] High Blood Pressure [Y][N] Diabetes [Y][N]
Stroke [Y][N] Cancer [Y][N] Depression [Y][N]

WORK HISTORY

Current occupation _____
History of exposure to chemicals, fumes, or asbestos _____
Any job related injury [Y][N]
Are you disabled [Y][N] Why? _____

SOCIAL HISTORY

Smoke [Y][N] How much? _____ packs/day Started _____ years ago Quit _____
Alcohol [Y][N] How many drinks? _____ per day or week (circle one)
Illegal Drugs [Y][N]
History of Sexually Transmitted Disease [Y][N]
Do you think you have any risk of AIDS [Y][N]

REVIEW OF SYSTEMS

Respiratory Tract

Chronic Cough [Y][N]
Sinus Trouble [Y][N]

Cough Blood [Y][N]
Allergy Shots [Y][N]

Short of Breath [Y][N]
Chest Pain [Y][N]

Heart and Blood Vessels

Chest Pain [Y][N]
Palpitations [Y][N]

Prior Heart Attack [Y][N]
Fluid in Legs [Y][N]

Leg Pain with Walking [Y][N]

Gastrointestinal Tract

Heartburn [Y][N]
Chronic Nausea [Y][N]
Chronic Diarrhea [Y][N]
Change in Stool [Y][N]

Ulcers [Y][N]
Cramping [Y][N]
Blood in Stool [Y][N]

Hiatal Hernia [Y][N]
Poor Appetite [Y][N]
Pain in Abdomen [Y][N]

Skin and Nails

Chronic Rash [Y][N] New or Changing Moles [Y][N] Frequent sun exposure [Y][N]

Neurologic

Frequent Headache [Y][N]
Fainting [Y][N]

Migraines [Y][N]
Double vision [Y][N]

Numbness [Y][N]
Seizures in Past [Y][N]

Skeletal System

Joint Pain [Y][N]
Back Pain [Y][N]

Broken Bones [Y][N]
Arthritis [Y][N]

Sprained Joints [Y][N]

Questions for MEN

Painful Urination [Y][N]
Penis Discharge [Y][N]

Difficult Urination [Y][N]
Nighttime Urination [Y][N]

Blood in Urine [Y][N]
Sexual Difficulty [Y][N]

Questions for Women

Painful Urination [Y][N]
Irregular Menses [Y][N]
Hot Flashes [Y][N]
Number of Children _____
Age at First Menses _____

Difficult Urination [Y][N]
Birth Control Pills [Y][N]
Sexual Difficulty [Y][N]
Date of Last PAP _____
Date of Last Menses _____

Painful Menses [Y][N]
Vaginal Discharge [Y][N]
Number of Pregnancies _____

General Questions

Difficulty Sleeping [Y][N] Loss of Enjoyment in Life [Y][N] Change in Appetite [Y][N]
Always Tired [Y][N] Always Hot or Cold [Y][N] Poor Concentration [Y][N]
Weight loss [Y][N] Weight Gain [Y][N]

ADDITIONAL INFORMATION

Any important information not asked above?

Patient Care of New Jersey

PREVENTIVE HEALTH MAINTENANCE

Please take a few moments to fill in the dates you last received these services.

Service

Month and Year

Colonoscopy- Colon Cancer Screening	
Eye Exam	
Complete Physical	
Hepatitis B Shot/Vaccine	
TB Skin Test- Tuberculosis Screening	
Lipid Profile/Cholesterol Check	
Tetanus Shot/Vaccine	
Pneumonia Shot/Vaccine	
Pap (Women)	
Dexascan- Bone Density (Women)	
Mammogram (Women)	
PSA - Prostate Screening (Men)	
Hemoglobin A1C (Diabetic)	
Urine Protein Test (Diabetic)	
Foot Exam (Diabetic)	