Date of Physical:

PRIMARY CARE ASSOCIATES OF NEW JERSEY, LLC
COMPLETE PHYSICAL HEALTH QUESTIONNAIRE

Name: Sex: Date of Birth:

Occupation / Employer: Marital Status:

LIST ALL ILLNESSES OR CONDITIONS YOU ARE PRESENTLY BEING TREATED FOR

CURRENT PRESCRIPTIONS	OTC MEDS & SUPPLEMENTS	ALLERGIES / REACTION / WHEN

PAST SURGERIES & HOSPITALIZATONS *not including pregnancies*	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

FAMILY HISTORY

Next to each family member listed, indciate the relative's **AGE, (A)live** or **(D)eceased ,** and their Health Status as **(G)ood** or **(P)oor**.Use the space provided to list any other significant medical conditions/ illnesses in family members.

Mother: Father:

Sisters: Brothers:

HEALTH HISTORY:

BELOW PLEASE INDICATE ALL **BLOOD RELATIVES OF THE PATIENT** WHO HAVE HAD ANY OF THE FOLLOWING PROBLEMS. PLEASE USE THE FOLLOWING ABBREVIATIONS: (P) PATIENT, (F) FATHER, (M) MOTHER, (B) BROTHER, (S) SISTER, (MM) MOTHER'S MOTHER, (MF) MOTHER'S FATHER, (FM) FATHER'S MOTHER, (FF) FATHER'S FATHER, (A) AUNT, (U) UNCLE, (C) COUSIN

Alcoholism	Bleeds easily	Early Deafness	High Blood Pressure	Osteoporosis	
Anemia	Blood Transfusions	Epilepsy	High Cholesterol	Seizures	
Arthritis	Cancer	Glaucoma	Joint Problems	Stroke	
Asthma	Cystic Fibrosis	Heart Disease	Mental Illness	Sudden Infant Death	
Birth Defects	Diabetes	Hepatitis	Migraine	Thyroid	

SOCIAL HISTORY

Do you consume alcohol? How many ounces per week? Preferred drink?

Do you consume caffeine? How many cups per day? Coffee / Tea / Soda

Do / did you smoke? How many cigarettes per day? For how many years? Year quit?

Do you do street drugs? What type? How often?

Do you exercise? What type of exercise? # of times per week? #of minutes per time?

SEXUAL HISTORY

Do you have problems with… Prostate? Premature Ejaculation? Attaining or sustaining an erection?

Any other problems with sexual enjoyment? If so, what?

Are you heterosexual? Homosexual? Bisexual?

Number of sexual partners in the last two years? Birth control method?

Please list the **year** of the last of the following vaccine:

Tetanus / TD	Hepatitis	Pneumonia	Influenza / Flu

Please list the **year** and **result** of the last of the following examination:

Rectal / Stool	Result:	TB Test	Result:	Eye Exam
Cholesterol	Result:	EKG	Result:	Dental Exam
Colonoscopy	Result:			

List any concerns and / or changes in medical or personal information we should know or you would like to discuss.

INSURANCE & BILLING INFORMATION

Primary Insurance Name:

Name of Insured: DOB:

Relation to Patient: Social Security #: