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

Is your menstrual flow regular? Menstrual pain or cramps? Pain / bleeding during or after sex?

Date of first day of last period: Number of days of flow? Length of cycle?

Flushing / Menopause? Birth control method? Name of Birth Control Pills?

# of sexual partners in the last 2 years? Are you heterosexual? Homosexual? Bisexual?

# of Pregnancies? # of Abortions? # of Miscarriages? # of Live Births?

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:	Mammogram	Result:
Cholesterol	Result:	EKG	Result:	Eye Exam	
Colonoscopy	Result:	Pap Test	Result:	Dental Exam	

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 #: