

MORRISTOWN MEDICAL GROUP, P.C.

MEDICAL HISTORY

Name _____

Allergies to Medications or other Substances Yes _____ No _____
(if yes, please list name of medicine and type of reaction)

Past Medical History

Please circle if you have had problems with or are presently complaining of any of the following:

- | | | | |
|-------------------------------|--------------------------|----------------------------------|--------------------|
| 1. High blood pressure | 13. Bronchitis | 26. Change in bowel habits | 38. Arthritis |
| 2. Diabetes | 14. Pneumonia | 27. Unexplained weight gain/loss | 39. Low back prob. |
| 3. Cancer | 15. Persistent cough | 28. Hemorrhoids | 40. Skin diseases |
| 4. Heart disease | 16. T.B. | 29. Gall Bladder disease | 41. Blood disorder |
| 5. Chest pain/chest tightness | 17. Hay fever | 30. Colitis | 42. Venereal dis. |
| 6. Shortness of breath | 18. Abdominal discomfort | 31. Hepatitis or jaundice | 43. Anxiety |
| 7. Swollen ankles | 19. Indigestion | 32. Thyroid disease | 44. Depression |
| 8. Palpitations | 20. Nausea | 33. Head or neck radiation | 45. Anemia |
| 9. Lightheadedness | 21. Vomiting | 34. Headache | 46. Alcohol abuse |
| 10. Frequent urination | 22. Constipation | 35. Kidney diseases | 47. Drug abuse |
| 11. Rheumatic fever | 23. Diarrhea | 36. Kidney stones | 48. Gout |
| 12. Asthma | 24. Blood in stool | 37. Difficulty urinating | 49. Ulcers |

Other: _____

Please List and Supply the Dates of:

Operations: _____

Hospitalizations: _____

When was your last:

Pap smear _____ Breast Exam _____ Stool check for blood _____
Mammogram _____ Cholesterol Check _____ Prostate Exam _____

Gynecologic and Obstetric History

Last menstrual period: _____ Pregnancies _____ Births _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety,depression)	_____	_____
Other	_____	_____

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name _____	Dose _____	Drug name _____	Dose _____
Drug name _____	Dose _____	Drug name _____	Dose _____
Drug name _____	Dose _____	Drug name _____	Dose _____
Drug name _____	Dose _____	Drug name _____	Dose _____

Prevention

Do you smoke? Yes _____ No _____ If yes, how many packs per day _____
Do you drink alcoholic beverages? Yes _____ No _____ If yes, how much per week _____
Do you drink coffee? Yes _____ No _____ If yes, how many cups per day - _____

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