

You now have the ability to email this form to a private/secure email at registrations@gsuni.com or it can be faxed to 973-556-1674 for your convenience, PLEASE DO NOT MAIL!!

Today's Date _____

ADULT HISTORY FORM

Patient Name: _____ DOB: _____

Primary Care Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit (New Patients ONLY) _____

Allergies: Please list any drug allergies (including latex and shellfish, if applicable.) Please circle NONE if you do not have any known allergies.

NONE

Medications: Please list all the medications you are currently taking (including OTC medications such as aspirin), dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If you are unable to fit all medications on the above list, please attach an additional page****

Past Surgical History: Please list all surgeries. Include approximate dates, if possible.

Procedure: _____ Date: _____ Procedure: _____ Date: _____

Procedure: _____ Date: _____ Procedure: _____ Date: _____

If you are unable to fit all your procedures/surgeries in the above space, please utilize the back of the page

Past Medical History: Do you have or have you had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	Heart Disease	YES	NO	Arthritis	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Indigestion	YES	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	Other:	_____	
Kidney Stones		YES	NO	If YES please specify:			_____			

Race (Optional): (Requested by the state of New Jersey for the Cancer Registry)

Caucasian African American American Indian Asian Indian/Pakistani
 Hispanic Asian Other _____

Family History: Do you have a *family* history of any of the following?

Prostate Cancer YES NO Bladder Cancer YES NO Kidney Cancer YES NO

Please list all serious illnesses in your *family* and indicate the relationship to you:

Social History:

Occupation: _____ Marital Status: _____ # of Children: _____

Do you currently smoke? YES NO Did you ever smoke? YES NO

How many packs per day? _____ When did you quit? _____

Do you drink alcohol? YES NO How many drinks per week? _____

Review of Systems: Do you now or have you had any problems related to the follow systems. **Please circle any that apply. If none apply, please circle None.**

Constitutional :	None	Fever	Chills	Other: _____	
Neurological :	None	Tremors	Dizzy spells	Other: _____	
Hematologic/ Lymphatic :	None	Clotting problems	Swollen glands	Blood transfusion	Other: _____
Musculoskeletal :	None	Joint pain	Neck pain	Other: _____	
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other: _____	
Psychological :	None	Depression	Psychosis	Other: _____	
Cardiovascular :	None	Chest pain	Heart attack	Heart murmur	Other: _____
Endocrine :	None	Excessive thirst	Tired/ Sluggish	Diabetes mellitus	Other: _____
Respiratory :	None	Emphysema	Shortness of breath	Other: _____	
Integumentary/ Skin :	None	Skin rash	Persistent itch	Other: _____	
Genitourinary :	None	Urinary tract infection	Blood in urine	Kidney stone	Other: _____

Physician Reviewed/Date: _____ Physician Reviewed/Date: _____ Physician Reviewed/Date: _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

Patient Signature: _____ **Date:** _____