TODAYS DATE_______________

ADULT HISTORY FORM

Patient Name: ____ DOB: ____________________

Primary Care Physician Name: ______________________________ Phone: ____________________

Other Treating Physician Name: ____________________________ Phone: ____________________

Other Treating Physician Name: ____________________________ Phone: ___________________

Pharmacy Name: ____ Phone: ___________________

Pharmacy Address:__________________________________City:___________State:_____Zip:_______

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

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******

Allergies: Please list any drug allergies (including latex and shellfish, if applicable.)

____

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? _______________

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:

____

____

Revised 08/2010

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

___Caucasian ___African American ___American Indian ___Asian Indian/Pakistani

___Hispanic ___Asian ___Other_______________________________________

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

Diabetes	YES	NO	Heart Disease	Yes	NO	Arthritis	YES	NO
Asthma	YES	NO	Thyroid Disease	YES	NO	GERD	YES	NO
High Blood Pressure	YES	NO	Cancer	YES	NO	Other (please list):		

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

Procedure	Date
____	______________
____	______________
____	______________
____	______________

Review of Symptoms: Please circle YES or NO if you experience the following symptoms.

Constitutional			**Gastrointestinal**			**Respiratory**		
Fever	YES	NO	Abdominal pain	YES	NO	Emphysema	YES	NO
Chills	YES	NO	Nausea/Vomiting	YES	NO	Shortness of breath	YES	NO
Other	YES	NO	Other	YES	NO	Other	YES	NO
Neurological			**Psychological**			**Integumentary**		
Tremors	YES	NO	Depression	YES	NO	Skin Rash	YES	NO
Dizzy Spells	YES	NO	Psychosis	YES	NO	Persistent Itch	YES	NO
Other	YES	NO	Other	YES	NO	Other	YES	NO
Hematological/Lymphatic			**Cardiovascular**			**Genitourinary**		
Clotting problem	YES	NO	Chest Pain	YES	NO	Urinary Tract Infection	YES	NO
Swollen glands	YES	NO	Heart Attack	YES	NO	Blood in Urine	YES	NO
Blood transfusion	YES	NO	Heart Murmur	YES	NO	Erectile Dysfunction	YES	NO
Other	YES	NO	Other	YES	NO	Kidney Stones	YES	NO
						Other		
Musculoskeletal			**Endocrine**					
Joint Pain	YES	NO	Excessive Thirst	YES	NO			
Neck Pain	YES	NO	Tired/Sluggish	YES	NO			
Other	YES	NO	Diabetes Mellitus	YES	NO			
			Other	YES	NO			

Provider reviewed/Date:__________ **Provider reviewed/Date:**_______ **Provider reviewed/Date:** _______

Provider reviewed/Date:__________ **Provider reviewed/Date:**_______ **Provider reviewed/Date:** _______

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

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Patient Signature:____ **Date:**_______________