DOCTORS MEDI CENTER

PATIENT HISTORY AND PHYSICAL FORM

835 Roosevelt Ave
Carteret, NJ 07008
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PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth / / | Social Security # - - | Male Female

Current Primary Care Physician | Specialists

Occupation | Company

PATIENT HISTORY

Please indicate whether or not you have had any of the following and when

	Circle One	If Yes, When?		Circle One	If Yes, When?
Heart disease, rheumatic fever	Yes No		Epilepsy, seizures	Yes No	
High blood pressure	Yes No		Dizziness, fainting spells	Yes No	
Chest pain, angina	Yes No		Frequent or severe headaches	Yes No	
Asthma, emphysema	Yes No		Ulcers, stomach trouble	Yes No	
Shortness of breath	Yes No		Hepatitis, Jaundice	Yes No	
Chronic cough	Yes No		Kidney, bladder disorder	Yes No	
Chronic bronchitis	Yes No		Arthritis	Yes No	
Tuberculosis	Yes No		Back injury or disorder	Yes No	
Diabetes	Yes No		Knee or joint problems	Yes No	
Allergies, hayfever	Yes No		Nervous or mental disorder	Yes No	
Skin disease	Yes No		Bowel problems, colitis	Yes No	
Anemia, blood disease	Yes No		Alcohol or drug abuse	Yes No	
Cancer	Yes No		Heart Attack	Yes No	

WHEN WAS YOUR LAST

Pneumonio Vaccine | Flu Shot | Colonoscopy | EKG

DEXA Scan | Shingles Vaccine | Tetanus Shot

WOMEN ONLY

Pap Smear | Mammogram

Menstruation | Breast Exam

MEN ONLY

Prostate Exam

Total Pregnancies | Births | Miscarriages

HAVE YOU EVER SMOKED?

☐ Yes # of Packs Per Day________

☐ No If you quit, when?________

ALCOHOL CONSUMPTION

☐ None ☐ Moderate Frequency:

☐ Social ☐ Heavy ________

FAMILY HISTORY

Diabetes | Heart Disease | Cancer | Hepatitis | Seizures | TB

Father's Age: | Mother's Age: | # of Siblings: | Age(s):

Other Health Problems: | Hospitalizations/Surgeries:

List All Current Medications

Allergies

I hereby authorize Doctors Medi Center to release/furnish all information concerning my Diagnostic Test, History and Physical Examination. I also assign these physicians all payments for medical services rendered to my department or myself. I understand that regardless of my insurance company or the party requesting this exam, I am ultimately resposible for charges produced by DMC

Patient________ Witness________ Date________