RWJ PHYSICIAN ENTERPRISE

SUA SOMERSET UROLOGICAL ASSOCIATES

Name: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Referring Physician: _____

PRESENT MEDICATION & DOSE:	REASON:	ALLERGIES:
1. _____	_____	1. _____
2. _____	_____	2. _____
3. _____	_____	3. _____
4. _____	_____	4. _____
5. _____	_____	5. _____
6. _____	_____	6. _____

Reason for your visit today: _____

_____

REVIEW OF SYSTEMS: Please indicate, by circling, if you have any of the following symptoms. Thank you

CONSTITUTIONAL: Fever Chills Weight Loss Chronic Headaches

EYES: Blurred Vision Pain in Eyes Double Vision

ALLERGY/IMMUNOLOGY: Foods Seasonal

NEUROLOGICAL: Tremors Numbness Tingling Dizzy Spells Confusion

ENDOCRINE: Excessive Thirst Feeling Hot or Cold Tiredness

GI: Nausea Vomiting Constipation Diarrhea Abdominal Pain

CARDIOVASCULAR: Varicose Veins High Blood Pressure Chest Pain

SKIN: Rash Boils Persistent Itch

MUSCOSKELETAL: Arthritis Bone Pain Joint Pain

EAR/NOSE/THROAT: Ear Aches Sinus Problems Sore Throat

RESPIRATORY: Wheezing Frequent Cough Shortness of Breath

HEMATOLOGIC/LYMPHATIC: Swollen Glands Blood Clotting

PSYCHOLOGIC: Anxiousness Depression

RWJ PHYSICIAN ENTERPRISE

SUA SOMERSET UROLOGICAL ASSOCIATES

Name: _____ Date of Birth: _____ Date: _____

MEDICAL HISTORY: Please indicate if you have any of the following medical conditions. Thank you

	Yes	No		Yes	No
Heart Disease	_____	_____	Stroke/Parkinson's/MS	_____	_____
Diabetes	_____	_____	Lung Disease/Asthma	_____	_____
Hepatitis/Liver Dis	_____	_____	Cancer	_____	_____
HIV/AIDS	_____	_____	Other _____		

SURGICAL HISTORY: Please list & kindly include the date

1. _____ _____ 4. _____ _____
2. _____ _____ 5. _____ _____
3. _____ _____ 6. _____ _____

FEMALE HISTORY: (IF APPLICABLE)

Last Menstrual Period _____

Total Number of Pregnancies _____ Pregnancies to Full Term _____

Total Number of Vaginal Deliveries _____ Cesarean Deliver _____

FAMILY HISTORY:

	Alive	Deceased	Cause of Death (if applicable)
Father:	_____	_____	_____
Mother:	_____	_____	_____

SOCIAL HISTORY:

Marital Status: _____ Number of Children: _____ Occupation: _____

Alcohol Consumption: (Yes) _____ (No) _____ Amt per Day _____

Tobacco Use: (Yes) _____ (No) _____ Packs per Day _____

Caffeinated Beverages (Yes) _____ (No) _____ Amt per Day _____