GARDEN STATE PHYSICIANS, P.C.,

10 Jefferson Plaza Ste.100, Princeton, NJ 08540
1002 Amboy Ave., Edison, NJ 08837

Name: _____ **Age:** _____ **Date:** _____

Past Medical History: Do you currently have:

Diabetes	Yes	No
Hypertension	Yes	No
Heart Problem	Yes	No
Cancer	Yes	No

Other Problems:

Surgeries: (You had in past)
1.
2.
3.

Previous Hospital Admission:

1.
2.
3.

Allergies : (To Medications)

Medications: (You are taking)

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

Social History:

Are you married, single, divorced, widowed? _____
How many children do you have? _____
What work do you do? _____
Do you smoke? **Yes** **No**
Do you drink alcohol? **Yes** **No**

Family History: Does anybody in your family have:

Diabetes	**No**	OR	if **YES**, who _____
Hypertension	**No**	OR	if **YES**, who _____
Heart Disease	**No**	OR	if **YES**, who _____
Cancer	**No**	OR	if **YES**, who _____

Date of your last physical examination: _____

Preventative Care: Have you ever had any of the following done? (IF YES, When?)

Men:			**Women:**		
Colonoscopy	**YES**	**NO**	Colonoscopy	**YES**	**NO**
PSA (Prostate test)	**YES**	**NO**	Mammogram	**YES**	**NO**
Stress Test	**YES**	**NO**	Pap Smear	**YES**	**NO**
Echocardiogram	**YES**	**NO**	Bone Density Test	**YES**	**NO**
Pneumococcal Vaccine	**YES**	**NO**	Pneumococcal Vaccine	**YES**	**NO**
			Stress Test / Echo		

List of Other Physicians / Specialist you are currently seeing:
1.
2.
3.

Patient's Signature _____ Date: _____