BERGEN GERIATRIC CARE

NEW PATIENT INFORMATION

Last name _____

First name _____

Social Security number _____

Date of birth _____

Marital status _____

Sex _____

Address _____

Room number _____

Phone number _____

Language _____ Race _____ Ethnicity _____

Emergency contact _____ Phone number _____

Health Care Proxy _____ Phone number _____

Power of Attorney _____ Phone number _____

Advance Directives in place? Yes No

If you do not have Advance Directives in place, who would you prefer we communicate medical needs/decisions with?

Name _____ Phone number _____

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HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer a question, or feel uncomfortable answering them, leave them blank. Thank you.

Name _____

Date of birth _____

Today's date _____

Please circle to indicate if you have ever had the following conditions:

Diabetes High blood pressure Asthma High cholesterol Kidney Disease

Hepatitis Thyroid Disease Stroke Tuberculosis Emphysema/COPD

Depression Seizures Coronary Artery Disease Congestive Heart Failure

Abnormal heart rhythm Eye problems

Sexually Transmitted Disease/Type _____ Cancer/Type _____

Other, please explain: _____

When was your last physical? _____

Please list any surgeries or hospital stays you have had and their approximate date/year.

Surgery	Reason for surgery	Date

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Surgery	Reason for surgery	Date

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

Please list all allergies and reactions to medications of which you aware.

Name of pharmacy _____ Phone number _____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals?

Yes _____ No _____

If yes, please provide name and the reason for which they are treating you:

_____ _____

_____ _____

_____ _____

Please note the approximate dates of your most recent immunizations:

Tetanus Date _____

Pneumonia Date _____

Influenza Date _____

Shingles vaccine Date _____

Other: Type _____ Date _____

Other: Type _____ Date _____

Other: Type _____ Date _____

Other: Type _____ Date _____

If you have had any of the following tests done, please note when the test were done and the results, if known:

Cholesterol _____

Pelvic exam/PAP Smear _____

Mammogram _____

Colonoscopy _____

Dexa (Bone density for Osteoporosis) _____

FAMILY HISTORY

Check any of the following that run in your family and please note their relation to you.

Alcoholism or drug abuse _____

Cancer (Type) _____

Diabetes _____

Heart Disease _____

High blood pressure _____

High cholesterol _____

Osteoporosis _____

Mental illness _____

Stroke _____

Thyroid Disease _____

Other _____

HEALTH HABITS

How would you describe your diet? Excellent Good Fair Poor

Do you exercise more than two times per week? Yes No

Do you smoke or use any tobacco products? Yes No

If so, how many cigarettes each day? _____ How many years? _____

Do you drink alcohol? Yes No Quit

If so, how much? _____ How often? _____

Have you ever felt you should cut down on your drinking? Yes No

PERSONAL HISTORY

Are you currently married or have a significant other? Yes No

Children? Yes No How many? _____

Previous profession _____ Retired by: Choice Disability Other reason:

Do you often feel sad or depressed? Yes No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury? Yes No

Do you have some form of church or spiritual support? Yes No

Do you have an advanced directive or living will? Yes No

Females Only:

Have you ever been pregnant? Yes No Number of times _____

Miscarriages(#) _____ Abortions(#) _____ Living children(#) _____