ADVANCED INTERNAL MEDICINE OF NORTH JERSEY PATIENT QUESTIONNAIRE

In preparation for your upcoming exam, please complete this form as thoroughly as possible and bring it with you to your appointment. ***Please continue on the back of the page if you require additional space.***

Name:_____ **Date of Birth:**_____

Current Medical History | These are conditions you are currently being treated for. Please check all that apply.

❑ Coronary Artery Disease	❑ Blood Clots	❑ Seizure Disorder
❑ COPD or Emphysema	❑ Bleeding Disorder	❑ Fainting Spells
❑ Asthma	❑ Head Injury	❑ Depression, Anxiety
❑ Respiratory Problems	❑ MRSA	❑ Diabetes-Need Insulin Y/N
❑ Elevated Cholesterol	❑ Kidney Problems (stones or infection)	❑ HIV/AIDS
❑ High Blood Pressure	❑ Liver Disease/ Hepatitis	❑ Osteoporosis
❑ Stroke	❑ Thyroid Problems	❑ Cancer-If yes what type? *Notes
*Notes:		

Surgeries	**Date**	**Hospitalized?**

Allergies | Please list allergies and type of reaction:

Allergy	Type of reaction? (e.g. rash, difficulty breathing, diarrhea, etc.)

Medications, Vitamins and Other Supplements

Medication/Vitamin/ Supplement	Dose (mg)	Times per Day

Medication/Vitamin/ Supplement	Dose (mg)	Times per Day

Are you taking any medicines that contain aspirin or anti-inflammatory medicines, such as Bufferin, Goody Powders, Motrin, Ibuprofen, Aleve, Excedrin? **Yes/No**

If yes, which one(s)? _____

Do you take any Vitamins, supplements, or over the counter medicines? **Yes/No**

If yes, which one(s)? _____

Are you on a special diet, and if so, why? _____

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Family History | Please check all that apply and provide details in *Notes area below.

❑ Alcoholism	❑ Respiratory Problems	❑ High Blood Pressure
❑ Cancers	❑ Asthma	❑ Kidney Disease
❑ Depression	❑ Head Aches	❑ Mental Illness
❑ Diabetes	❑ Seizures	❑ Stroke
❑ Bleeding Disorder	❑ Heart Attack	❑ Thyroid Disease
❑ Blood Clots	❑ Heart Disease	❑
❑ Liver Problems	❑ High Cholesterol	❑
*Notes:		

Social History

Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑
Sports or extracurricular activities:
Tobacco use or exposure? If so describe.
Do you drink alcohol? Yes/No How much per week?
Do you use drugs? (marijuana, cocaine, narcotics, etc.) Yes/No
Have you been Treated for drug or alcohol dependence? Yes/No
Occupation: Currently employed Yes/No
Pets:

Providers and Suppliers | Please list other health care providers and suppliers (i.e. for diabetic supplies, oxygen, etc.)

Provider/Supplier Name	Specialty	What care do they provide?

Advanced Care Planning:
I consent to discuss end-of-life planning with my healthcare provider at my upcoming appointment. **Yes / No**

_____ _____
Patient Signature Date