**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: | | |

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| --- | --- | --- |
| **Surgeries** | **Date** | **Hospitalized?** |
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**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 |
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|  |  |  |
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|  |  |  |
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|  |  |  |
| --- | --- | --- |
| Medication/Vitamin/Supplement | Dose (mg) | Times per Day |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCED INTERNAL MEDICINE OF NORTH JERSEY PATIENT QUESTIONNAIRE**

**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? |
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**Advanced Care Planning:**

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

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Patient Signature Date