Raritan Family Healthcare

NAME:_____DOB_____ DATE:_____

Past Medical history	Past Surgical History	Family History/medical issues
		M alive? Y N
		F alive? Y N
		Siblings

Current medications (dosage & frequency)	Allergies

Smoker? Y N if Y year started? Packs per day? Stopped?
Drug use? Y N if Y what type/amount?
Alcohol use? Y N if Y what type/amount?
Profession?
Married Single divorced Widowed Children?
What is your Exercise/Activity Level? NONE LOW MEDIUM HIGH
In the past month-Do you have little interest or pleasure in doing things? Not at all several days more than ½ the day every day In the past month- Do you have feelings of being down/depressed or hopeless? Not at all several days more than ½ the day every day
Are you worried about running out of food or having enough money to buy food? Often sometimes Never Have you had food that didn't last and not have enough money to buy more? Often sometimes Never
Last colonoscopy and where?
Last mammogram & dexa scan and where?
Last eye exam and where?
Do you have an Advanced Directive/Living Will?
What are your specific goals for your health?