Skylands Medical Group, P.A.

HISTORY SHEET

DATE: ____________

Name: ____________ Phone: ____________ DOB: ____________

YOUR MEDICAL HISTORY (CHECK WHERE APPLICABLE):

☐ Hypertension	☐ Bleeding Disorders	☐ Mental Illness
☐ Diabetes	☐ Asthma	☐ Musculoskeletal Disease
☐ High Cholesterol	☐ Heart Murmur	☐ Mononucleosis
☐ Seizures (Epilepsy)	☐ Phlebitis	☐ Vaginal Infections
☐ Stroke	☐ Hepatitis	☐ Ear Diseases
☐ Heart Attack	☐ Arthritis	☐ Pneumonia
☐ Heart Disease	☐ Rheumatic Fever	☐ Urinary Tract Infection
☐ Lung Disease	☐ Scarlet Fever	☐ Glaucoma
☐ Tuberculosis	☐ Thyroid Disease	☐ Cataracts
☐ Stomach Ulcers	☐ Gallstones	☐ Chicken Pox
☐ Diverticulitis	☐ Cancer	☐ Measles
☐ Kidney Disease	☐ Pancreatitis	☐ Liver Disease
☐ Kidney Stones	☐ Neurological Disease	☐ Sinusitis

YOUR SURGICAL HISTORY (LIST ALL OPERATIONS & DATES): ____________

____

____

MEDICATIONS: ____________

____

ALLERGIES TO MEDICATION/FOOD ☐ YES ☐ NO If yes, please list: ____________

____

SOCIAL HISTORY

Have you ever smoked? ☐ YES ☐ NO

Do you smoke now? ☐ YES ☐ NO

How many per day/week? ____________

Do you drink alcohol? ☐ YES ☐ NO

How many per day/week? ____________

How many caffeinated beverages do you drink per day? ____________

Have you served in the military? ☐ YES ☐ NO

Have you ever lived in another country? ☐ YES ☐ NO

Where? ____________ How long ago? ____________

Do you now use any recreational drugs? ☐ YES ☐ NO

Marital Status: ☐M ☐S ☐W

Occupation: ____________

FAMILY HISTORY - Name Any Blood Relative(s) or Siblings, Parents, or Grandparents:

Colon Cancer	☐ YES ☐ NO	Prostate Cancer	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Lung Cancer	☐ YES ☐ NO	Penile Cancer	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Breast Cancer	☐ YES ☐ NO	Testicular Cancer	☐ YES ☐ NO	Alcohol/Drug Abuse	☐ YES ☐ NO
Ovarian Cancer	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Mental Illness	☐ YES ☐ NO
Cervical Cancer	☐ YES ☐ NO	Heart Attack	☐ YES ☐ NO	Neurological Disease	☐ YES ☐ NO
Uterine Cancer	☐ YES ☐ NO	Gastrointestinal Disease	☐ YES ☐ NO	Stroke	☐ YES ☐ NO