Atlantic
Medicine & Wellness

2399 Route 34 Suite A-5 Wall Township, NJ 08736
Phone: (732) 528-5533 Fax: (732) 528-0360
www.amwwall.com

PATIENT PERSONAL HISTORY FORM

NAME: _____

(PLEASE PRINT)

Date: _____/_____/_____ D.O.B.: _____/_____/_____

Preferred phone number: _____

May we leave you a detailed voicemail with results: YES/NO

Primary Care Physician: _____

Date of Last Physical: _____/_____/_____

Pharmacy name: _____ Phone no:_____

Address: _____ _____

REASON FOR YOUR VISIT TODAY:

1.	2.
3.	4.

PAST MEDICAL HISTORY: *please circle all that apply*

Circulatory system:

High blood pressure
Heart attack
Peripheral vascular disease
Atrial fibrillation
Coronary artery disease
Deep vein thrombosis
Other: _____

Pulmonary system:

COPD/Emphysema
Pulmonary Embolism
Pneumonia
Asbestosis
Asthma
Sleep Apnea
Tuberculosis
Other: _____

NAME:_____ **DOB:** _____ **DATE:**_____

Gastrointestinal:

GERD	Ulcerative colitis
Crohn's disease	Irritable Bowel Syndrome
GI Bleeding	Leaky Gut Syndrome
Other: _____	

Endocrine/Metabolic:

Diabetes Type I or II	Hyperlipidemia
Hypothyroidism	Hyperthyroidism
Osteoporosis	Obesity
Other: _____	

Neurologic:

Stroke	TIA
Migraines	Seizure disorder
Tremors	Parkinson's disease
Dementia	Neuropathy
Vertigo	Restless leg syndrome
Other:_____	

Hematologic:

Anemia	B12 deficiency
Thrombocytopenia	Leukemia
Other:_____	

Renal:

Renal Insufficiency	Renal Failure
Kidney stones	Pyelonephritis
Other:_____	

Urinary System:

BPH	Prostatitis
Incontinence	Hematuria
Erectile Dysfunction	
Other: _____	

Head and Neck:

Allergic rhinitis	Chronic sinusitis
Meniere's Disease	Hearing loss
Cataracts	Glaucoma
Macular degeneration	
Other: _____	

Infectious Disease:

Mononucleosis	Lyme disease
Hepatitis	HPV
Genital herpes	HIV
Chlamydia	
Other: _____	

NAME:_____ **DOB:** _____ **DATE:**_____

Psychiatry:

Anxiety	Depression
Attention Deficit Disorder	Bipolar Disorder
Substance Abuse	
Other:_____	

Musculosketal:

Osteoarthritis	Rheumatoid Arthritis
Lupus	Gout
Fibromyalgia	Spinal disc disease
Other:_____	

Female Health History:

Irregular Menstrual cycle	Polycystic Ovarian Syndrome
Fibrocystic breast disease	Uterine fibroids
Other:_____	

Cancer:

Breast	Lung
Colon	Renal
Thyroid	Lymphoma
Melanoma	Bladder
Prostate	
Other:_____	

PAST SURGICAL HISTORY:

Appendix	Joint replacement (please list type)
Tonsils	Pacemaker
Gall bladder	Hysterectomy
Cardiac Catheterization/Stent	
Other:_____	

Last mammogram:	Date:_____	Result: _____
Last PAP:	Date:_____	Result: _____
Last DEXA:	Date:_____	Result: _____
Last colonoscopy:	Date:_____	Result: _____
Pneumonia vaccine:	Date:_____	
Tetanus shot:	Date:_____	

SOCIAL HISTORY:

Do you smoke?	YES: ____ packs/day Never a smoker:_____
	FORMER SMOKER: Years smoked: _____Date quit: _____
Caffeine:	YES/NONE: _____cups/day
Alcohol use:	YES/NONE: type: _____ amount per day/week/social: _____
Substance use:	YES/NONE: type: _____ amount per day/week/social: _____

NAME:_____ **DOB:** _____ **DATE:**_____

FAMILY HISTORY:

Family Member	Living/Deceased	Age	Medical Conditions/Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son(s)/Daughter(s)	_____	_____	_____
Other	_____	_____	_____

ALLERGIES:

No Known Drug Allergies
Medication Allergies: _____
Food Allergies: _____
Environmental Allergies: _____
Other:_____

MEDICATIONS: *please list all **medications**, including **over the counter**, **vitamins** and **supplements***

Drug	Dosage and directions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NAME:_____ **DOB:** _____ **DATE:**_____

REVIEW OF SYSTEMS: *Please check all that apply*

Constitutional

- ☐ Fever
- ☐ Malaise
- ☐ Fatigue
- ☐ Chills
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Poor Sleep
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss

Comments:_____

Eyes

- ☐ Vision Changes LT___Rt___
- ☐ Vision Loss LT___Rt___
- ☐ Blurred Vision LT___Rt___
- ☐ Redness LT___Rt___
- ☐ Discharge LT___Rt___

Comments:_____

Ears

- ☐ Difficulty hearing LT___Rt___
- ☐ Tinnitus LT___Rt___
- ☐ Pain LT___Rt___
- ☐ Discharge LT___Rt___

Comments:_____

Nose

- ☐ Discharge
- ☐ Congestion
- ☐ Post Nasal Drip
- ☐ Sinus Pressure
- ☐ Sneezing

Comments:_____

Mouth/Throat/Neck

- ☐ Sore Throat
- ☐ Discharge
- ☐ Swollen lymph nodes
- ☐ Comments:_____

Pulmonary **(Please circle all that apply)*

- ☐ Shortness of breath *(At rest/with exertion)
- ☐ Cough *(Dry/Wet/barking/at night/general)
- ☐ Sputum (Please list color_____)
- ☐ Wheezing
- ☐ Noisy Breather

Comments:_____

Cardiovascular

- ☐ Chest Pain (Please describe_____)
- ☐ Palpitations
- ☐ Shortness of breath while laying flat
- ☐ Shortness of breath that wakes you from sleep
- ☐ Pain in legs while walking
- ☐ Ankle swelling

Comments:_____

Gastrointestional **(Please circle all that apply)*

- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation *(intermittent or continuous)
- ☐ Change in bowel habits *(Pain or Bleeding)

Comments:_____

NAME:_____ **DOB:** _____ **DATE:**_____

Urinary

- ☐ Painful urination
- ☐ Blood in urine
- ☐ Urinating frequently at night
- ☐ General urgency
- ☐ General frequency

Comments:_____

Female Genital

- ☐ Pregnant
- ☐ Vaginal Discharge
- ☐ Abnormal Bleeding
- ☐ Genital sore/lesion

Comments:_____

Male Genital

- ☐ Penile discharge
- ☐ Erectile dysfunction
- ☐ Testicular dysfunction
- ☐ Testicular/scrotal Mass
- ☐ Testicular/scrotal Pain
- ☐ Genital Sore/lesion

Comments:_____

Breast

- ☐ Pain
- ☐ Mass
- ☐ Nipple Discharge

Comments:_____

Musculoskeletal **(please list location)*

- ☐ Joint pain _____
- ☐ Muscle Pain _____
- ☐ Swelling _____
- ☐ Stiffness _____
- ☐ Back pain
- ☐ Neck pain
- ☐ Cramps at night
- ☐ Muscle spasms
- ☐ Injury _____

Comments:_____