CUMBERLAND FAMILY MEDICINE ASSOCIATES LLC
BOARD CERTIFIED IN FAMILY MEDICINE
1203 NORTH HIGH STREET, SUITE A
MILLVILLE, NEW JERSEY 08332

MEDICAL HISTORY FORM

NAME:____ DOB:____________________
TODAY'S DATE:

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

****BRING ALL MEDICATIONS OR A COMPLETE UP TO DATE LIST WITH YOU TO YOUR APPOINTMENT****

List your prescribed drugs, inhalers and over-the-counter drugs, such as vitamins		
Medication name	Strength (mg, mcg)	How many times per day?
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	Exercise type ☐ walking ☐ biking ☐ swimming ☐ weight training ☐ yoga ☐ none ☐ other ________________________________					
	How often? ☐ 1-2 days/wk ☐ 2-3 days/wk ☐ 3-4 days/wk ☐ 4-5 days/wk ☐ 5-6 days/wk ☐ 6-7 days/wk					
	How long? ☐ < 15 min ☐ 15-30 min ☐ 30-45 min ☐ 45 min - 1 hour ☐ 1 hour or more					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No

	With men, women or both?		
	If protection/contraceptive used specify what type.		
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you own a gun? ☐ Yes ☐ No If yes, is it kept in a locked box?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No	Have you ever attempted/contemplated suicide?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No	Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No	Do you have any trouble falling asleep or staying asleep?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No	Have you ever been to a counselor?	☐ Yes	☐ No
Do you cry frequently?				☐ Yes	☐ No

EDUCATION	
Circle highest grade completed	
Elementary School	1 2 3 4 5 6 7 8
High School	9 10 11 12
GED	
Vocational School	1 2 3
College	1 2 3 4+

WOMEN ONLY

Number of pregnancies ______ Number of live births _______		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Date of last pap, mammogram and rectal exam? PAP ________________ Mammogram ________________ Rectal Exam _________________		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Heart	☐ Kidney
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Stomach	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	