1910 Highway 35 South• Oakhurst, NJ 07755 • Phone: 732-531-0100• Fax: 732-531-0144
Web: www.familyfirst-urgentcare.com

NAME: _____ DATE OF BIRTH: _____ AGE: ____
Email_____

Reason for visit: _____

Is this a work related injury? Y / N **Car accident related injury? Y / N**

Primary care physician name and location of office:
_____

Pharmacy (Name and Location):_____

Date of last tetanus shot:_____

CURRENT MEDICATIONS (prescription and over the counter)	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

Please list any medical disease that you have that is not mentioned above:
_____

ALLERGIES	REACTION (hives, anaphylaxis, etc.)

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PAST SURGERIES	DATE	SURGEON

FAMILY HISTORY	Status (Alive/Deceased)	Age	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other
Grandfather (maternal)							
Grandmother (maternal)							
Grandfather (paternal)							
Grandmother (paternal)							
Father							
Mother							
Brother							
Brother							
Sister							
Sister							

Please list any medical disease that a member of your family has that is not mentioned above:
_____

SOCIAL HISTORY

Do you smoke? ☐ Current ☐ Former ☐ Nonsmoker

If yes, how much do you smoke?
3 ☐ cigarettes or less ☐ ½ pack per day ☐ 1 pack per day +

If smoker/former smoker, how long have you smoked? _____

Do you drink alcohol? YES or NO

If yes, how frequent? ☐ Social ☐ Several times a week ☐ Everyday

Do you wear glasses or contacts? _____

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Date of last menstrual period: _____