



Family First Primary Physicians, LLC
 1806 Highway 35 South
 Oakhurst, NJ 07755
 Phone: 732.531-4747
 Fax: 732.663-0044

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? _____

Date of last menstrual period: _____