OFFICE OF SIDNEY J. GOLDFARB, M.D., F.A.C.S.

419 N. Harrison Street, Suite 206, Princeton, NJ 08540
Tel: 609-921-3008 Fax: 609-921-7533

Name: _____ **Date**:_____

Chief Complaint (Please describe, in detail, the main reason for your visit today.)

_____

_____

_____

History of Present Illness (Briefly describe the location of the problem, its severity, and how long it has been going on. How long does it last? Is it constant or variable? Any aggravating and relieving factors? Any related problems, e.g. nausea, rash, headache…?)

_____

_____

_____

Past/Current Medical Problems ☐None
(Please list any serious illnesses (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

_____

_____

_____

Hospitalizations/Surgeries ☐None

Date	Hospitalization/Surgery	Comments

History of Radiology Studies

Date	Radiology	Results

Family Medical History ☐None
(Please list any serious illnesses in your immediate family.)

Relation	Age	Health	Living/Deceased	Comments

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Social History

Do you Smoke? ☐Yes ☐No ☐Formerly; Date Quit:_____

If yes, how many packs/cigarettes per day?_____ packs / cigarettes (circle one)

How long have you been smoking/did you smoke?_____

Status ☐ Current daily smoker ☐ Current occasional smoker ☐ Never smoker

Tobacco (chew) ☐Yes ☐No

Alcohol ☐Yes ☐No

Drugs ☐Yes ☐No

Coffee ☐Yes ☐No

Tea ☐Yes ☐No

Caffeine (soda) ☐Yes ☐No

Exercise ☐Yes ☐No

Blood Transfusion ☐Yes ☐No

Foreign Travel ☐Yes ☐No If **yes**, please list only your most recent travel info:

Where? _____ When? _____

HIV Test ☐Negative ☐Positive ☐Not Done ☐No Result

Hepatitis B ☐Positive ☐Negative ☐Normal

Marital Status ☐Married ☐Divorced ☐Single ☐Widowed ☐Other

Number of Children _____

Born ☐Out of Country ☐Within Country

Occupation _____

Do you have high blood pressure (hypertension)? ☐ Yes ☐ No ☐ Don't know

If YES, are you being treated and/or taking medication for hypertension? ☐ Yes ☐ No

Have you received an influenza immunization (flu shot) this season? ☐ Yes ☐ No ☐ Don't know

If YES, when? Month/Year: _____

If you are 65 or older, have you ever received a pneumococcal vaccine? ☐ Yes ☐ No ☐ Don't know

Have you been discharged from any inpatient facility (e.g. hospital, nursing or rehabilitation facility) **for any reason within the past 30 days?** Yes ☐ No

If YES, please note the approx. discharge date: _____

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Current Medications ☐Not currently taking any medications

Rx Date (when started?)	Drug Name	Number	SIG (dosage instructions, e.g. once daily)	Refills	Name of doctor who prescribed medication

Herbal / Non Prescription Medications (please list)

_____

_____

_____

_____

Allergies ☐No known Drug Allergies ☐ No known Allergies (non-drug)

Allergy	Severity	Status	Adverse Reaction

Preventive Care

Date	Preventive Care	Results/Comments
	Colonoscopy	
	Cytology	
	FISH	
	Osteoporosis Screening	
	Mammogram	
	Pap Smear	
	Other:	

PSAs ☐None

Date	Results

Date	Results

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Review of Systems

Height_____ **Weight**_____

Do you now or have you had any problems related to the following systems? Check Yes or No.

Constitutional Symptoms

Fever	☐Yes	☐No	Headache	☐Yes	☐No
Chills	☐Yes	☐No	Other_____		

Skin

Skin rash	☐Yes	☐No	Boils	☐Yes	☐No
Persistent Itching	☐Yes	☐No	Other_____		

Ear/Nose/Throat/Mouth

Ear Infection	☐Yes	☐No	Sinus Problems	☐Yes	☐No
Sore Throat	☐Yes	☐No	Other_____		

Eyes

Blurred Vision	☐Yes	☐No	Double Vision	☐Yes	☐No
Pain	☐Yes	☐No	Other_____		

Respiratory

Wheezing	☐Yes	☐No	Shortness of breath	☐Yes	☐No
Frequent cough	☐Yes	☐No	Other_____		

Cardiovascular

Chest Pains	☐Yes	☐No	Varicose Veins	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Other_____		

Gastrointestinal

Abdominal Pain	☐Yes	☐No	Indigestion/Heartburn	☐Yes	☐No
Nausea/Vomiting	☐Yes	☐No	Bowel Complaints	☐Yes	☐No
Other_____					

Endocrine

Excessive Thirst	☐Yes	☐No	Tired/Sluggish	☐Yes	☐No
Too Hot/Cold	☐Yes	☐No	Weight Gain	☐Yes	☐No
Dry Skin	☐Yes	☐No	Hair Loss	☐Yes	☐No
Other_____					

Musculoskeletal

Joint Pain	☐Yes	☐No	Back Pain	☐Yes	☐No
Neck Pain	☐Yes	☐No	Other_____		

Neurological

Tremors	☐Yes	☐No	Numbness/Tingling	☐Yes	☐No
Dizzy Spells	☐Yes	☐No	Other_____		

Psychiatric

Are you generally satisfied with your life?	☐Yes	☐No
Do you feel severely depressed?	☐Yes	☐No
Other_____		

Hematologic/Lymphatic

Swollen Glands	☐Yes	☐No	Blood Clotting Problem	☐Yes	☐No
Other_____					

Genitourinary

Urine Retention	☐Yes	☐No	Urinary Frequency	☐Yes	☐No
Painful Urination	☐Yes	☐No	Urine Leaking	☐Yes	☐No
Painful Sex	☐Yes	☐No	Urinary Incontinence	☐Yes	☐No
Lack of Interest in Sex	☐Yes	☐No	Erectile Difficulty	☐Yes	☐No
Other_____					

Allergic/Immunologic

Hay Fever	☐Yes	☐No	Drug Allergies	☐Yes	☐No
Other_____					

Would you like a clinical summary of today's visit? ☐Yes ☐No