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:_____

Do you currently smoke? ☐ Yes ☐ No

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

Were you 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: _____

Has your insurance information changed since your last visit? ☐ Yes ☐ No ---------->> **If YES, please complete:**

Primary Insurance Name:_____ **Subscriber's Name:**_____

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other **Subscriber's DOB:**_____

Policy ID#_____ **Group#**_____

Secondary Insurance Name:_____ **Subscriber's Name:**_____

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other **Subscriber's DOB:**_____

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

Have you had any medical problems since your last visit (Ex: diabetes, tuberculosis, breast cancer, heart disease, etc.)?

_____

_____

Current Medications ☐ No change

Have you started taking any new medications since your last visit? Please list below:

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

Have you discontinued any medications since your last visit? Please list below:

Date Stopped	Drug Name	Name of doctor who prescribed medication

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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