John Madej, MD & Jessica Madej, MD

New Patient Information

Name	First	Middle	Last	Date of Birth
Address				
City, State, ZIP				
Phone Number	Home		Cell	
Email Address				
Alternate Contact	Name	Relationship	Phone Number	
Preferred Pharmacy				
Occupation				
Primary Insurance				

Name_____ Date _____

Topics for Discussion at Today's Visit:

_____

_____

Surgeries & Serious Injuries (e.g., MVA)

TYPE	YEAR

Past Medical History (Circle All That Apply):

High Blood Pressure, Heart Attack, Coronary Atherosclerosis, Stroke

High Cholesterol, High Triglycerides, Thyroid Disorder, Diabetes

Asthma, Emphysema, COPD, Allergies

Gallstones, Hepatitis, Liver Disease, Ulcers, Colonic Polyps, Diverticulitis

Frequent Urinary Infections, Kidney Stones, Other Kidney Disease, Prostate Problems.

Auto-Immune Disorder (Specify: _____), Osteoporosis, Arthritis, Gout

Anemia, Iron Deficiency, Bleeding Disorder, History of DVTs/Blood Clots, Migraine

Cancer (Specify: _____)

Other: _____

Please list the names of any Specialists you see (e.g., Rheumatologist, Cardiologist):

_____

_____

Name_____ Date _____

Health Screenings (Indicate year of procedure if applicable):

- Colonoscopy: _____
- Mammogram: _____
- Pap Smear: _____

Family History

RELATION	AGE	PLEASE CIRCLE	PLEASE NOTE HEALTH HISTORY
MOTHER	____	Alive/Deceased	
FATHER	____	Alive/Deceased	
SIBLING	____	Alive/Deceased	
SIBLING	____	Alive/Deceased	

Please circle if you any family history of the following:

- High Blood Pressure, Stroke, Diabetes
- Heart Attack, Heart Disease
- Cancer
- Hereditary/Genetic Disorders

Lifestyle & Social History

Dietary Habits/Restrictions: _____

Tobacco Use: Yes / No Average cigarettes/day: ____ Duration: ____ years

- If you quit, when? _____

Alcohol Intake: None / Occasional / More than 2 drinks/day

Marijuana Use: None / Occasional / Regular

Name_____ Date _____

Review of Systems (Circle Any That Apply)

General: Significant weight change (>10 lbs) in past year

Head: Frequent/severe headaches, vision or hearing issues

Respiratory: Persistent cough, shortness of breath, wheezing

Cardiovascular: Chest pain, discomfort, palpitations

Gastrointestinal: Swallowing difficulty, severe indigestion, abdominal pain, bowel changes, chronic diarrhea, constipation, blood in stools

Urinary: Frequent/painful urination, night urination, bladder leakage, difficulty emptying bladder, sexual difficulties

Women's Health: Last pap smear/pelvic exam: _____ Age of menopause: _____
Number of pregnancies: ____ Number of deliveries: ____ History of estrogen use
History of abnormal pap smears, vaginal bleeding, discharge, breast discharge/lumps/pain

Musculoskeletal: Joint pain, back pain

Skin: Rashes, lesions of concern

Neurological: Dizziness, numbness/tingling in hands or feet, fainting spells, memory changes

Mood: Difficulty sleeping, depression, anxiety, other: _____