Montclair Surgical Associates, PA
Joseph Barbalinardo, MD, FACS
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New Patient Medical Information Form

Name_____ Date of Birth_____ Age_____

Reason for seeing the doctor today_____

Please check off any of the following disorders from which you currently suffer or have suffered in the past.

Cardiovascular
- ☐Hypertension
- ☐Angina
- ☐Heart Attack - Date(s)_____
- ☐Arrhythmia
- ☐Heart Murmur
- ☐Bleeding Disorder
- ☐Poor Circulation/ Edema
- ☐Phlebitis/Leg Ulcers
- ☐High Cholesterol/Triglycerides

Genitourinary
- ☐Urinary Tract Infection
- ☐Kidney Stone
- ☐Renal Failure
- ☐Need for Dialysis
- ☐Kidney Tumor
- ☐Enlarged Prostate
- ☐Prostate Cancer
- ☐Sexually Transmitted Disease
- ☐HIV

Gastrointestinal
- ☐Ulcers
- ☐Hiatal Hernia/GERD
- ☐Stomach Cancer
- ☐Gallbladder Disease
- ☐Colon Polyps/Cancer
- ☐Diverticulosis
- ☐Intestinal Obstruction/Adhesions
- ☐Hepatitis/Jaundice
- ☐Crohn's/Ulcerative Colitis

Pulmonary
- ☐Asthma
- ☐Bronchitis
- ☐COPD
- ☐Pneumonia
- ☐Lung Cancer
- ☐Snoring/Sleep Apnea
- ☐Tuberculosis

Endocrine (Glands)
- ☐Diabetes Mellitus
- ☐Thyroid Disease
- ☐Parathyroid Disease
- ☐Pituitary Disease
- ☐Adrenal Disease
- ☐Ovarian Disease
- ☐Testicular Disease

Neurological
- ☐Stroke/TIA
- ☐Seizures/Epilepsy
- ☐Paralysis/Palsy
- ☐Multiple Sclerosis
- ☐Brain Tumor
- ☐Alzheimer's Disease
- ☐Spine Problem

Social History
- ☐Cigarettes - packs/day___x___yrs.
- ☐Alcohol - drinks/day_____
- ☐Drug Abuse - type_____

Allergies to Foods & Medications

_____
_____
_____

Current Medications/Dose

_____
_____
_____
_____
_____
_____
_____

Use Back of Page if Room Needed

Prior Hospitalizations/Surgeries

_____
_____
_____
_____
_____
_____
_____

Use Back of Page if Room Needed

Family History of Illnesses

Mother_____

Father_____

Sisters_____

Brothers_____

Others_____

Breast Disease Risk Assessment

Age at Menarche_____ Age at Menopause_____
Pregnancies_____ #Children_____
Age at 1st Full Term Pregnancy_____
Have you ever taken Hormones/BCP? ☐yes ☐no
Did you ever breast feed? ☐yes ☐no
Have you ever had a breast biopsy? ☐yes ☐No
Family History of Breast Cancer_____