Ocean Medical Group
401 Lacey Rd
Ste B
Whiting, NJ 08759

Name: ____

Address: ____

City: ____________________ State: __________ Zip: __________

Phone Number: _______________________________________

Date of birth: _________________ Marital status: _____________

Social Security Number: __________________________________

Email Address: _______________________________________

Pharmacy: ____

Emergency Contact: ____________________________________

Relationship to pt: ______________ Number: ________________

I hereby consent to treatment by Ocean Medical Group.

Date: _____________ Signature: ____________________________

Surgeries: **Dates:**

____
____
____
____
____
____
____
____
____

Hospital stays: **Dates:**

____
____
____
____
____
____

When was your last:

Tetanus shot: ____________________
Flu shot: _______________________
Pneumonia shot: ___________________
Zostavax shot: ______________________

Medication List

Name	Dose	Frequency

Medical History:

Check If you have or had any of the following:

__Diabetes
__Heart Disease
__Hypertension
__Tuberculosis
__Asthma
__Stroke
__Cancer____(kind)
__Hernia
__High cholesterol
__Lyme Disease
__Emphysema
__Liver Disease
__Hepatitis C
__Rheumatic Fever
__Bleeding tendencies
__Stomach Ulcer
__Glaucoma
__Thyroid Disease
__Kidney Disease
__Diverticulitis
__Anxiety
__Depression
__Aids/Hiv
__Copd
__Nervous Breakdown
__Shingles

Any Allergies:

_______________________ Reaction_________________________

_______________________Reaction__________________________

_______________________Reaction__________________________

_______________________Reaction__________________________

Social History:

Do you have any children? __________

How many daughters? _____

How many sons? _____

How many brothers? ____

How many sisters? ____

Father- alive/deceased   Condition?______________________

Mother alive/deceased Condition? ______________________

Do you smoke? Yes/No
Recreational drugs? Yes/No
Do you exercise? Yes/No
Do you have a smoke detector in home? Yes/No
Do you drink caffeine? Yes/No
Drink alcohol? Yes/No
Are you sexual active? Yes/No
Travel outside the United States? Yes/No
Are you retired? Yes/No
What kind of occupation____________________