Pilgrim Medical Center Inc.

393 Bloomfield Avenue
Montclair, NJ 07042
973-746-1500

PATIENT # ______________ TIME ADMITED _____________

DATE _____________ BED _____________

ALL INFORMATION GIVEN HERE IS STRICTLY CONFIDENTIAL

Last Name First Middle	Sex	Birthdate	Age	Race

Address (Street) Apt.# City State Zip Code	Best Contact Phone Number

Marital Status	Employed	Usual Occupation	Have you ever been a patient at Pilgrim Medical Center Inc.? ☐ Yes ☐ No What year? _______	May we leave a message ☐Yes ☐No

RESPONSIBLE PERSON FOR NEXT 12/24 HRS

Name Relationship to you		Address (Street) City State Zip Code
Best Contact Phone Number	**May we leave a message** ☐Yes ☐No	**CAN WE DISCLOSE MEDICAL INFORMATION ABOUT YOUR CARE, MEDICAL HISTORY AND NOTIFY THIS PERSON IN CASE ON AN EMERGENCY?** ☐ YES ☐ NO **SIGNATURE** ____________________________________ **DATE** ______________

MEDICAL HISTORY

Date of Last Period _____________ **# of Weeks** _________

Have you had the following?

	YES	NO
Heart Trouble	☐	☐
Varicose Veins	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Thyroid Disease	☐	☐
Any Drug Allergies?	☐	☐
Irregular Period	☐	☐
Symptoms of a cold	☐	☐
Rheumatic fever	☐	☐
Epilepsy	☐	☐
Hypertension	☐	☐

	YES	NO
Kidney Disease	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Operations	☐	☐
Antibiotics	☐	☐
"Social Drugs"	☐	☐
Psychiatric History	☐	☐
Bleeding Tendencies	☐	☐
Other	☐	☐

Medication recently taken:

____

____

Previous number of:

Living Children _____

Miscarriages _____

Abortions _____

C-Sections _____

Ectopic _____

Deceased _____

Total previous pregnancies _____

Previous Hospitalizations: ____

Method of Birth Control: ____

Have you had anything to eat or drink since 12 midnight? ☐ YeS ☐ No

If yes, please explain: ____

M.D. Signature _________________________ Date ______________

Montclair Physicians Group LLC

Name of person driving me home ____ **Phone** ___________________________________

I have completely and honestly disclosed my medical history, including allergies, medication(s) taken, and reactions I have to anesthetics, medications and drugs.
I consent to my Physician relying on this disclosure as complete. I assume all responsibility for any problems or complications arising as a result of any pertinent history.

Patient's Signature ____ **Date** _________________

Revised 12/2018 cl

DO NOT CONTINUE