PATIENT # ______________

Pilgrim Medical Center Inc.

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

PROCESSED TIME _____________

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	Are You Employed?	Usual Occupation	Have you ever been a patient at Pilgrim Medical Center Inc.?	May we leave a message
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐Yes ☐No		☐ Yes ☐ No What year? _______	☐Yes ☐No

RESPONSIBLE PERSON FOR THE NEXT 12/24 HRS

First and Last Name	Relationship to you	Address (Street)	City	State	Zip Code

Best Contact Phone Number	May we leave a message	MAY WE DISCLOSE MEDICAL INFORMATION ABOUT YOUR CARE, MEDICAL HISTORY AND NOTIFY THIS PERSON IN CASE ON AN EMERGENCY? ☐ YES ☐ NO
	☐Yes ☐No	SIGNATURE ____________________________________ DATE ______________

MEDICAL HISTORY

Date of Last Menstrual Period ___________

Have you had the following?

	YES	NO
Any Drug/Food Allergies? ___________	☐	☐
Varicose Veins	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Thyroid Disease	☐	☐
Bleeding Tendencies	☐	☐
Irregular Period	☐	☐
Symptoms of a cold	☐	☐
Rheumatic fever	☐	☐
Epilepsy / Seizures	☐	☐
Hypertension	☐	☐

	YES	NO
Kidney Disease	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Operations	☐	☐
Social Drugs ________	☐	☐
Psychiatric History	☐	☐
Fibroids	☐	☐
Other	☐	☐

Current medication(s) being taken:

____

____

Previous number of:

Living Children _____

Vaginal Birth _____

C-Sections _____

Miscarriages _____

Abortions _____

Ectopic _____

Deceased _____

Total previous pregnancies _____

Pharmacy Name and Phone Number: ____

Previous Hospitalizations: ____

Have you had anything to eat or drink since 12 midnight? ☐ **YeS** ☐ **No** **If yes, please explain:** ___________________________________

MD 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** _________________

DO NOT CONTINUE