6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

I. Patient Information

First Name:		Middle Name:	
Last Name:		Date of Birth (MM/DD/YYYY):	
Sex Assigned at Birth: ☐ Male ☐ Female		Gender Identity / Pronouns:	
Address:			
City:		State:	
ZIP:		Cell Phone:	
Email: *Required for patient portal access*		Home Phone:	
Preferred Contact Method: ☐ Call ☐ Text ☐ Email			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____			
Preferred Language:		Interpreter Needed:	
Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other: _____			
Emergency Contact:		Relationship:	
Phone:			
Employer:		Occupation:	
Employer Address:			
Pharmacy Name:		Pharmacy Phone:	
Pharmacy Address / Cross Streets:			

II. Insurance Information

Primary Insurance:		Policy/Group #:	
Cardholder Name:		Insured Date of Birth:	
Relationship to Patient (Self / Spouse / Child / Other):			
Secondary Insurance:		Policy/Group #:	
Cardholder Name:		Insured Date of Birth:	
Relationship to Patient (Self / Spouse / Child / Other):			

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III. Medical History

Are you currently being treated for, or have you ever had, any of the following? Check all that apply.

☐ None / no significant history

Heart / Circulation ☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ Heart failure ☐ Arrhythmia	**Lungs / Breathing** ☐ Asthma ☐ COPD / Emphysema ☐ Sleep apnea ☐ Tuberculosis	**Musculoskeletal** ☐ Arthritis ☐ Chronic pain ☐ Fibromyalgia ☐ Back / joint issues
Endocrine / Metabolic ☐ Diabetes (Type ☐1 ☐2) ☐ Thyroid condition ☐ Obesity ☐ Osteoporosis	**Neurologic** ☐ Stroke / TIA ☐ Seizures ☐ Migraines ☐ Neuropathy	**Genitourinary** ☐ Kidney disease ☐ Kidney stones ☐ Prostate problems ☐ Urinary incontinence
Digestive ☐ GERD / Reflux ☐ Ulcers ☐ IBS ☐ Liver disease / hepatitis	**Psychiatric** ☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ ADHD	**Immune / Blood** ☐ Anemia ☐ Cancer ☐ Autoimmune disease ☐ Frequent infections

Infectious Disease / Exposure History

☐ Tuberculosis exposure or positive test ☐ Hepatitis (A / B / C) ☐ HIV / AIDS

Other significant medical conditions / Notes:

Any recent hospitalizations / ER visits (past 12 months)? ☐ No ☐ Yes
If yes, please specify date(s), reason, and facility name

IV. Past Surgeries / Procedures

Please detail past surgeries and include an approximate year if known. ☐ None

_____

_____

_____

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V. Allergies & Reactions

☐ No known allergies *If yes, please specify any drug, food or environmental allergen:*

Allergen	Reaction

Allergen	Reaction

VI. Current Medications

List prescription and over-the-counter medications, birth control, supplements or vitamins. ☐ None

Medication	Dose	Frequency

VII. Primary Care Provider & Other Specialists Involved in Your Care

☐ Moukdad Medical - New PCP ☐ Moukdad Medical - Existing / Current PCP

☐ Other PCP provider Name: _____ Phone: _____

Prior PCP Last Visit: _____ Name: _____ Phone: _____

List the other doctors or healthcare providers you see regularly.

Provider Name	Specialty	Phone / Office

☐ I consent to receive appointment reminders or medical information via text or email.

☐ I would like access to my Moukdad Medical patient portal.

☐ I am interested in using telehealth visits when appropriate.

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VIII. Preventive Care Snapshot

Test	Have you had this done?	If yes, approx. year	Result / Notes
Annual Physical Exam	☐ Yes ☐ No ☐ Unsure		
Colonoscopy / Stool Test	☐ Yes ☐ No ☐ Unsure		
Mammogram (if applicable)	☐ Yes ☐ No ☐ Unsure		
Pap Smear (if applicable)	☐ Yes ☐ No ☐ Unsure		
Bone Density (if applicable)	☐ Yes ☐ No ☐ Unsure		
Eye Exam	☐ Yes ☐ No ☐ Unsure		
Dental Exam	☐ Yes ☐ No ☐ Unsure		
Hearing Screen	☐ Yes ☐ No ☐ Unsure		
Skin Check / Dermatology Exam	☐ Yes ☐ No ☐ Unsure		
PSA / Prostate screening (if applicable)	☐ Yes ☐ No ☐ Unsure		

Vaccine	Have you had this done?	If yes, approx. year
Tetanus (Td or Tdap)	☐ Yes ☐ No ☐ Unsure	
COVID-19 Vaccine	☐ Yes ☐ No ☐ Unsure	
Flu Shot	☐ Yes ☐ No ☐ Unsure	
Shingles	☐ Yes ☐ No ☐ Unsure	
Pneumonia	☐ Yes ☐ No ☐ Unsure	
RSV	☐ Yes ☐ No ☐ Unsure	
HPV	☐ Yes ☐ No ☐ Unsure	
Other: _____	☐ Yes ☐ No ☐ Unsure	

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IX. Family History

Please list any significant conditions such as high blood pressure, diabetes, heart disease, cancer, stroke or other hereditary illnesses. ☐ Unknown / Adopted

Family Member	Condition / Diagnosis	Age of Onset (if known)
Mother		
Father		
Siblings		
Other (Relative): _____		

X. Social History

Please tell us about your daily habits and environment to help us provide more personalized care.

Social Factor	Response
Tobacco Use	☐ Never ☐ Former ☐ Current How much / how often: _____
Alcohol Use	☐ No ☐ Yes How much / how often: _____
Recreational Drug Use	☐ No ☐ Yes Type / Frequency: _____
Exercise	☐ Rare ☐ Occasional ☐ Regular Type / Frequency: _____
Mobility / Assistive Device	☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____
Caffeine	☐ Occasionally ☐ Daily Amount: _____
Living Situation	☐ Live alone ☐ With family/partner ☐ Other: _____
Sleep Quality	☐ Good ☐ Fair ☐ Poor
Stress Level	☐ Low ☐ Moderate ☐ High
Work Environment	☐ Sedentary ☐ Physical ☐ High stress ☐ Other: _____
Advance Directive / Living Will	☐ Yes ☐ No ☐ Unsure

XI. Signature

I certify that the information provided is true and complete to the best of my knowledge.

Patient Signature: _____ **Date:** _____