

158 DANBURY ROAD ~ RIDGEFIELD, CT 06877

MEDICAL AND HEALTH HISTORY

A. Identification

Name: Age: Birthdate: Sex: M / F
Address: City: State: Zip:
Phone: (H) (W) (C) (F) Occupation:
Social Security # How did you hear of us?
Email Address: Family Status: Single / Divorced / Married / Widow / Significant Other
Emergency Contact: Phone: (H) (C)

B. Insurance Information

Primary Insurance: Policy #: Group ID:
Patient's relationship to insured: Self / Spouse / Child / Other
Insured's Name (holder of policy): Insured's SS#: DOB:
Secondary Insurance: Policy #: Group ID:
Patient's relationship to insured: Self / Spouse / Child / Other

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS AND RELATED CLAIMS. I REQUEST PAYMENT TO MYSELF OR TO THE PARTY WHO PROVIDED THE CARE.

c. Chief Complaint

Please list your major problems and/or symptoms and the approximate date it began (if none, please write your reason for seeking this consultation). Please rank in order of importance to you.

Table with 2 columns: PROBLEM AND/OR SYMPTOM, DATE PROBLEM BEGAN

If you have seen other practitioners for these problems, indicate the results of these evaluations:

Two horizontal lines for text input.

D. Past Medical History

Please indicate if you have had any of the following problems in the past. Please note years affected.

Alcoholism	Diabetes	Hypoglycemia	Mental Illness	Stomach/Intestinal Ulcers
Allergies	Digestive Disease	Hepatitis	Migraine Headache	Tuberculosis
Anemia	Drug Problems	High Cholesterol	Multiple Sclerosis	Thyroid Disease
Arthritis	Eating Disorder	High Blood Pressure	Pneumonia	Venereal Disease
Asthma	Emphysema/COPD	Irritable Bowel	Prostate Disease	
Cancer	Heart Disease	Kidney Disease	Rheumatic Fever	
Crohn's Disease	Herpes	Lupus/Autoimmune	Stroke/TIA	
Depression	HIV	Lyme Disease	Seizures	

Do you have a primary care provider? ___Yes ___No

If yes, please complete provider's information:

Name: _____ Address: _____ Phone: _____

If you have a specialist, please complete:

Name: _____ Address: _____ Phone: _____

Specialty: _____

Testing: Specify the dates of the last if known:

TEST	DATE PERFORMED	TEST	DATE PERFORMED
Physical Exam		Rectal Exam	
Chest X-Ray		Colonoscopy/Sigmoidoscopy	
EKG		PAP Smear	
Blood Tests		Breast Exam	
Urine Tests		Mammogram	

Immunizations: Specify when received if known:

IMMUNIZATION	DATED RECEIVED	IMMUNIZATION	DATE RECEIVED
TD-Tetanus/Diphtheria		Pertussis	
Influenza		Hepatitis B	
Smallpox		Chicken Pox	
Polio		Other	
Measles / Mumps / Rubella			

Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

E. Family History

For each family member, please list their age and health problems (if any). If deceased, give cause and age at death.

Example: Mother: Alive age 65 – has diabetes / stomach ulcers

Father: Died age 70 – heart attack / high blood pressure

	Age	Health Problems / Deceased?
Mother		
Grandmother		
Grandfather		
Father		
Grandmother		
Grandfather		
Siblings		
Children		

F. Current Medications

Please write name, dosage and how often taken.

PRESCRIPTION MEDICATIONS	OVER THE COUNTER MEDICATIONS

Are you allergic to any medications/substances? No Yes _____

G. Lifestyle and Habits

Tobacco

Do you currently smoke? Yes / No Do you currently chew? Yes / No If yes, how much per day? _____ For how long? _____. If no, did you ever smoke? Yes / No For how long? _____ When did you stop? _____

Alcohol (including wine, beer and liquor)

How often do you drink? Never Less than 1x per week 2-5x per week at least once daily

What do you drink? _____ Was drinking ever a problem? Yes / No

Caffeine

How many cups/cans of the following do you consume daily? Coffee Black Tea (or Iced Tea)

Green Tea Cola Diet Cola Chocolate

Have you used any recreational drugs in the past year? No Yes (type frequency) _____

Have you ever used intravenous drugs in your lifetime (even once)? No Yes (type / frequency) _____

Do you exercise regularly? No Yes (type / frequency) _____

H. Review of Systems

Please check next to the symptoms that you have experienced over the past 6 months.

General	Skin	Eyes	Ears	Nose
Fevers	Dryness	Eye Pain	Excessive Wax	Runny Nose
Night Sweats	Rashes	Redness	Discharge	Nasal Discharge
Insomnia	Itching	Discharge	Itching	Sneezing
Frequent Colds/Flu	Nail Fungus	Itching	ringing / Tinnitus	Frequent Bleeding
Fatigue	Brittle Nails	Excessive Tearing	Decreased Hearing	Frequent Snoring
		Dryness		
		Blurred Vision		
		Poor Night Vision		
Mouth	Throat	Endocrine	Cardio/Pulmonary	Gastrointestinal
Oral Sores	Frequent Soreness	Intolerance to Heat	Shortness of Breath	Heartburn
Funny Taste	Difficulty Swallowing	Intolerance to Cold	Palpitations	Bloating/Gas
Bad Breath	Painful Swallowing	Shakiness	Cough	Nausea
Coating on Tongue	Change in Voice	Fatigue	Chest Pain	Vomiting
	Frequent Clearing Throat	Increased Appetite	Leg Cramps when Walking	Hemorrhoids
	Hoarseness	Decreased Appetite	Leg Cramps at Night	Black or Dark Stools
		Weight Gain/Loss	Varicose Veins	Blood in Stools
		Sweat Easily	Lightheadedness	Constipation
		Cold Hands/Feet	Passed Out	Diarrhea
		Hair Loss/Thinning	Leg Swelling	Thin Stools
		Excess Facial Hair		
		Eyebrows Thinning		
Neurological	Mental/Emotional	Musculoskeletal	Genitourinary	Men Only
Numbness of a Limb	Anxiety	Joint Pain	Difficulty Urinating	Testicular Lumps
Weakness of a Limb	Depression	Muscle Aches	Cloudy Urine	Penile Discharge
Tension Headaches	Suicidal Thoughts	Back Pain	Involuntary Loss of Urine	Penile Lesions
Migraine Headaches	Panic Attacks	Morning Stiffness	Frequent Urination	Impotence
Room Spinning	Nervousness		Nighttime Urination	Breast Enlargement
Head Trauma				
Memory Loss				

