88 Norwich New London Tpke
Suite 1
Uncasville, Ct 06382

Phone:860-848-4180

Fax: 860-848-3471

**Patient Name** **Date of Birth**

Date:

**Medications:** Please List all medications that you currently take (including vitamins and/or supplements)

| Medication Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies**: Please list any allergies you have to medication and food (please list the type of reaction.

| Medication/Food Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**What pharmacy do you use?** _____

**Preventative Health:** Please provide the dates of below (if known)

| | Date | | Date |
|---|---|---|---|
| Pap Smear/Pelvic Exam (females) | | Tetanus Vaccine (Tdap) | |
| Mammogram (females) | | Flu Vaccine | |
| Colonoscopy | | Pneumonia Vaccine | |
| Rectal Prostate Exam (males) | | Shingles Vaccine | |
| Prostate Specific Antigen (males) | | Eye Exam | |
| Bone Density (DEXA) | | Other: | |

**Safety:**

1. Do you feel safe at home? Yes No

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**Past Medical History:** Please check the box if you have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| | No prior medical history | | Chronic venous stasis disease (swelling in legs) | | Glaucoma |
| | Anemia | | CHF (Heart Failure) | | Hepatitis |
| | Aortic Aneurysm | | Chronic Pain* | | High Cholesterol |
| | Angina | | Cirrhosis | | HIV/AIDS |
| | Anxiety | | Chronic Obstructive Pulmonary Disease (Lungs) | | High Blood Pressure |
| | Arrhythmia (irregular heartbeat) | | Stroke (CVA or TIA) | | Kidney Stones |
| | Arthritis | | Pressure Ulcer (Decubitus Ulcer) | | Kidney Disease/Insufficiency |
| | Asthma | | Depression | | Kidney Failure |
| | Atrial fibrillation | | Diverticulosis/Diverticulitis | | Lyme Disease |
| | Bi-polar disorder | | Diabetes | | Migraines |
| | BPH (enlarged Prostate) | | DVT (Blood Clot in arm or leg) | | Pulmonary Embolism |
| | CAD (Heart Disease) | | Fibromyalgia | | Peripheral Vascular Disease |
| | CAD with MI (heart attack) | | Gastric Peptic Ulcer (stomach ulcer) | | Seizure |
| | Cancer* | | GERD | | Thyroid Disease |
| | Carotid Stenosis (narrowing of carotid artery) | | GI Bleed | | Uterine Fibroids |
| | Cataracts | | Other: | | |

**Cancer: Please Specify what type & age you were diagnosed:*_____
_____

**Chronic Pain: Please Specify Location & How Long:* _____

**Surgical History**: Please check the box if you have had any of the following.

| | | | | | |
|---|---|---|---|---|---|
| | No prior history | | Cardiac Stents | | Replacement, Hip |
| | Aortic aneurysm repair | | Cataract surgery | | Replacement, Knee |
| | Appendectomy | | CEA (carotid endarterectomy) | | Spine Surgery |
| | AV fistula | | Cesarean section | | Tonsillectomy |
| | Bariatric Surgery | | Gall Bladder Removal | | Transplant |
| | Bowel Resection | | Hysterectomy | | Tubal Ligation |
| | Cardiac Bypass (CABG) | | IVC Filter | | Valve Replacement |
| | Cardiac Defibrillator AICD | | Lumpectomy | | Cardiac Bypass |
| | Mastectomy | | Other: | | |

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**Social History**: Please answer the following questions regarding your health and habits.

| | | | | | |
|---|---|---|---|---|---|
| **Smoking Status:** | | | | | |
| | Never Smoked | | Current some day smoker | | Former Smoker |
| | Current every day smoker: Packs per day:_____ | | | | |
| **Alcohol use:** | | | | | |
| | Do not drink | | Heavy use | | Other:_____ |
| | Occasional Use | | Alcoholic | | |
| **Recreational Drug Use:** | | | | | |
| | Do Not Use Drugs | | Cocaine | | Heroin |
| | THC | | Prescription Drugs | | Other: |
| Unhealthy Behavior: | | | | | |
| | Poor Nutrition | | Second Hand Smoke | | None |
| | Poor Oral Health | | Choose Not to Answer | Other: | |
| | Risky sexual behavior | | Gambling | | |

**Family Medical History**: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

| | *Yes* | *No* | *If Yes, what relative* | *Age at Diagnosis* |
|---|---|---|---|---|
| Aortic Aneurysm | | | | |
| Asthma | | | | |
| CAD (Heart Disease) | | | | |
| MI (Heart Attack) | | | | |
| Cancer (Please Specify)* | | | | |
| CVA, TIA (Stroke) | | | | |
| Diabetes | | | | |
| DVT (Blood Clot in Arm/Leg) | | | | |
| GERD (Reflux) | | | | |
| High Cholesterol | | | | |
| High Blood Pressure | | | | |
| Kidney Stones | | | | |
| Mental Illness | | | | |
| Migraines | | | | |
| Ovarian Cyst | | | | |
| PE (Pulmonary Embolism) | | | | |
| Kidney Failure | | | | |
| Seizure | | | | |
| Thyroid Disease | | | | |
| Uterine Fibroids | | | | |
| Other: | | | | |

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**Review of Systems:** Please check yes or no for the following **current** symptoms (Within the last 3 months)

| **Constitutional** | **Yes** | **No** | | Leg Ulcers | **Yes** | **No** |
|---|---|---|---|---|---|---|
| Appetite Change | | | | Peripheral edema (leg swelling) | | |
| Excessive Sweating | | | | **Respiratory** | | |
| Fatigue | | | | Cough | | |
| Fever | | | | Sputum production | | |
| Night Sweats | | | | Hemoptysis (coughing up blood) | | |
| Weight Gain | | | | Shortness of Breath | | |
| Weight Loss | | | | Pleuritic pain (pain with breathing) | | |
| **Eyes** | | | | Wheezing | | |
| Blurred Vision | | | | Snoring | | |
| Corrective lenses | | | | Apnea | | |
| Diplopia (double vision) | | | | **Gastrointestinal** | | |
| Eye Irritation | | | | Abdominal Pain | | |
| Eye Pain | | | | Bloating | | |
| Spots in vision | | | | Food Intolerance | | |
| Vision Loss | | | | Nausea | | |
| **Ears, nose, mouth, throat** | | | | Vomiting | | |
| Ear Pain | | | | Dysphasia (trouble swallowing) | | |
| Hearing loss | | | | Reflux/Heartburn | | |
| Tinnitus (ringing in the ear) | | | | Change in bowel habits | | |
| Vertigo | | | | Constipation | | |
| Facial Pain | | | | Diarrhea | | |
| Nasal Discharge | | | | Black stools | | |
| Nasal obstruction | | | | Bloody Stools | | |
| Nosebleeds | | | | **Genitourinary** | | |
| Postnasal drainage | | | | Change in urinary stream | | |
| Bleeding gums | | | | Dysuria (pain with urination) | | |
| Dental Pain | | | | Hematuria (blood in your urine) | | |
| Mouth Lesions | | | | Incontinence (urinary leakage) | | |
| Hoarseness | | | | Vaginal Discharge | | |
| Sore Throat | | | | Nocturia (urinating during sleep) | | |
| **Cardiovascular** | | | | Urinary Frequency | | |
| Chest Pain | | | | Urinary Urgency | | |
| Decreased exercise tolerance | | | | Dyspareunia (pain with sex, woman) | | |
| Short of Breath | | | | Dysmenorrhea (pain with menses) | | |
| Orthopnea(difficulty breathing while laying flat | | | | Penile discharge | | |
| Palpitations (feel your heart beating) | | | | Sexual dysfunction | | |
| Syncope (passing out) | | | | Post-menopausal | | |
| Claudication (leg pain w/ walking) | | | | | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| **Musculoskeletal** | **Yes** | **No** | | **Endocrine** | **Yes** | **No** |
| Back Pain | | | | Polydipsia (drinking frequently) | | |
| Joint Pain | | | | Polyphagia (eating frequently) | | |
| Joint Swelling | | | | Polyuria (urinating frequently) | | |
| Limited Range of motion | | | | Abnormal menstrual pattern | | |
| Muscle aches | | | | **Hematologic/lymphatic:** | | |
| Muscle weakness | | | | Bruising | | |
| Stiffness | | | | Bleeding Tendencies | | |
| **Integumentary** | | | | Lymphadenopathy | | |
| Hair Changes | | | | Recurrent infections | | |
| Lesions/changes in moles | | | | Allergic/Immunologic | | |
| Nipple discharge | | | | Eczema | | |
| Pigment Changes | | | | Seasonal Allergies | | |
| Pruritus (itchy skin) | | | | Urticaria (hives) | | |
| Breast skin changes | | | | **Psychiatric** | | |
| Rash | | | | Anxiety | | |
| Breast Masses | | | | Decreased Concentration | | |
| **Neurologic** | | | | Irritability | | |
| Abnormal gait | | | | Panic Attacks | | |
| Focal weakness | | | | Sleep Disturbance | | |
| Headache | | | | Sadness/Tearfulness | | |
| Changes in coordination | | | | | | |
| Memory problems | | | | | | |
| Numbness | | | | | | |
| Seizures | | | | | | |
| Slurred Speech | | | | | | |
| Tremor | | | | | | |

**Is there anything else we should know that would be helpful to us in your healthcare?** _____
_____
_____

**Females Only:**

Date of last menstrual cycle? _____

Is there any possibility of pregnancy? Yes or No

Are you currently pregnant? Yes or No If yes how many weeks: _____

Are you currently breast feeding? Yes or No