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Branford, CT 06405
203.915.9125

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (work) _____

(cell)_____ Is it ok to leave a message?_____

Age ____ Date of Birth _____ Social Security Number_____Gender_____

Marital Status: Race_____ Ethnicity_____

Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Emergency Contact _____

Relationship _____ Phone _____

Address _____

With in the past 24 months, please list the health practitioners you have seen for health care services:

Practitioner	Specialty	Condition seeking treatment for	Date	# of visits	Level of Satisfaction 1= very, 5= not at all	Reason for Satisfaction or Dissatisfaction

Were the above services covered by your insurance? YES NO

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

GENERAL

Weight_____lbs. Weight one year ago_____lbs. Max. Wt_____lbs. When?_____

Height_____

Any major Traumas?_____

_____

Family History

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check (√)those Applicable								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Mental Illness								
Asthma/Hayfever/Hives								
Allergies								
Eczema/Psoriasis								
Anemia								
Kidney Disease								
Glaucoma								
Tuberculosis								
Other								

Current Medications: Do you regularly take or use: (circle):

Laxatives Pain Relievers Antacids Cortisone Appetite suppressants
Antibiotics Tranquilizers Thyroid Medication Sleeping pills

Please list any prescription medications and over the counter medications you are taking, include dose and frequency:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list any vitamin or other supplements you are taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies

Are you hypersensitive or allergic to any of the following:
Any drugs?_____

Any Supplements?: _____

Any foods?_____

Any environmentals?_____

Hospitalization and Surgery

Have you had any hospitalizations or surgeries? YES NO
If yes, for what condition?

_____ year:_____ _____ year:_____

_____ year:_____ _____ year:_____

Typical Food Intake:

Breakfast:_____
Lunch: _____
Dinner:_____
Snacks:_____
Beverages: _____

Habits:

Please list your main interests and hobbies: _____
On average, how often do you exercise (circle):
Never 1-2 times/ week 3-5 times/week >5 times/week
Type of exercise:_____

On average, how much sleep do you get each night? (circle)
< 6 hours 6-8 hours >8 hours

Do you sleep well? YES NO
Do you awaken rested? YES NO

Do you have a supportive relationship? YES NO
Do you have a history of abuse? YES NO

Do you drink alcoholic beverages? YES NO How many drinks weekly? _____

Do you use recreational drugs? YES NO
Have you been treated for chemical dependence? YES NO
Do you use tobacco? YES NO How much per day?_____

Do you enjoy your work? YES NO
Do you go on vacations? YES NO How often? _____

Do you spend time outdoors? YES NO
Do you watch television? YES NO If yes, how many hours/day?_____
Do you read? YES NO If yes, how much? _____

What do you enjoy most in your life?_____
Do you have a religious/ spiritual practice? YES NO If yes, what type?: _____

How does your illness affect you? _____
_____

How much change are you willing to make at this time for improving your health? (circle):

MINIMAL SOME COMPLETE

For all of the following sections:

Y = a condition you have now **N** = never had **P** = a condition you had previously

Childhood Illnesses					
Scarlet Fever	Y N P	Diphtheria	Y N P	Rheumatic Fever	Y N P
Mumps	Y N P	Measles	Y N P	German Measles	Y N P
Immunizations					
Polio	Y N	Pertussis	Y N	Flu	Y N
Tetanus	Y N	Diphtheria	Y N	Chicken Pox	Y N
Measles/Mumps/Rubella	Y N	Hep B	Y N	H. Influnzae (HIB)	Y N
Musculoskeletal					
Joint pain or stiffness	Y N P	Broken bones	Y N P	Weakness	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P	Sciatica	Y N P
Blood/Peripheral Vasc.					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P	Thrombophlebitis	Y N P
Mental/Emotional					
Treated for emotional problems	Y N P	Considered/ Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P
Mood swings	Y N P	Depression	Y N P	Memory problems	Y N P
Poor concentration	Y N P	Tension	Y N P	History of Abuse	Y N
Endocrine					
Hypothyroid	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Hyperthyroid	Y N P	Excessive thirst	Y N P	Weight loss/gain	Y N P
Hypoglycemia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P

Immune					
Chronic Fatigue Synd.	Y N P	Chronic Infections	Y N P	Slow wound healing	Y N P
Chronic swollen glands	Y N P	Reactions to vaccinations	Y N P		
Neurologic					
Seizures	Y N P	Paralysis	Y N P	Muscle weakness	Y N P
Numbness or Tingling	Y N P	Loss of memory	Y N P	Easily stressed	Y N P
Vertigo or dizziness	Y N P	Loss of balance	Y N P		
Skin					
Rashes	Y N P	Acne, Boils	Y N P	Itching	Y N P
Itching	Y N P	Color Change	Y N P	Lumps	Y N P
Perpetual hair loss	Y N P	Night sweats	Y N P		
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P
Jaw/TMJ problems	Y N P				
Eyes					
Spots in Eyes	Y N P	Cataracts	Y N P	Impaired vision	Y N P
Glasses or contacts	Y N P	Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P	Double vision	Y N P
Glaucoma	Y N P				
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Earaches	Y N P
Dizziness	Y N P				
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Hayfever	Y N P	Sinus problems	Y N P	Loss of smell	Y N P
Mouth and Throat					
Frequent sore throat	Y N P	Copious saliva	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P		
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	Y N P
Pain or stiffness	Y N P				
Respiratory					
Cough	Y N P	Sputum	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Short of breath lying down	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Difficulty breathing	Y N P	Pain on breathing	Y N P	Shortness of breath	Y N P
Short of breath at night	Y N P	Tuberculosis	Y N P	Pneumonia	Y N P

Cardiovascular					
Heart disease	Y N P	Angina	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Phlebitis	Y N P	Rheumatic fever	Y N P
Swelling in ankles	Y N P	Chest pain	Y N P		
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Bowel movements	how often?			Is this a change?	Y N
Urinary					
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P
Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P		
Male Reproduction					
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge	Y N P	Sores	Y N P
Premature ejaculation	Y N P	Impotence	Y N P		
Are you sexually active?	Y N	Sexual orientation?		Birth control type?	
Female Reprod./Breast					
Age of first menses		Are cycles regular?	Y N	Length of cycle	
Age of last menses		Duration of menses		Clotting	Y N P
Bleeding between cycles	Y N P	Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Light flow	Y N P	PMS	Y N P
PMS symptoms?					
Pain during intercourse	Y N P	Endometriosis	Y N P	Ovarian cysts	Y N P
Are you sexually active?	Y N P	Sexual orientation?			
Birth control	Y N P	What type?			
Number of pregnancies		# of Live births		# of miscarriages	
Number of abortions		Abnormal PAP	Y N P	Breast self-exams?	Y N P
Breast pain/tenderness	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P
Breast feeding	Y N P	Mastitis	Y N P		
Menopause	Y N P	Menop. symptoms	Y N P		

Welcome! We're happy to serve you. If you have any questions, please ask!