The Hospital of Central Connecticut
Center for Metabolic Health

☐ Single ☐ Divorced ☐ Date form was

Name:_____ ☐ Married ☐ Widowed filled out:_____
LAST MIDDLE FIRST

Age:_____ Date of Birth:_____ Birthplace (City and State):_____

Current Occupation:_____ Who/How were you referred to us?_____
(If retired… ——————►prior occupation)

Soc. Sec. No._____ Education: _____ yrs. High School _____ yrs. College _____ yrs. Graduate School
Address:_____

Telephone #'s: (H_____ (W) _____ (Cell) _____

Please list all major symptoms/problems in order of importance and/or issues you would like to discuss.

1_____ 4 _____

2_____ 5 _____

3_____ 6 _____

PERSONAL HISTORY

ALLERGIES Have you ever had:

Please circle all answers			Date
High blood pressure	no	yes	_____
Cong. heart failure	no	yes	_____
High cholesterol	no	yes	_____
Mitral valve prolapse	no	yes	_____
Heart attack	no	yes	_____
Blood clot / Phlebitis	no	yes	_____
Stroke / Min-stroke	no	yes	_____
Diabetes	no	yes	_____
Kidney problems	no	yes	_____
Asthma	no	yes	_____
Emphysema	no	yes	_____
Stomach ulcer	no	yes	_____
Colitis	no	yes	_____
Kidney stones	no	yes	_____
Cirrhosis	no	yes	_____
Tuberculosis	no	yes	_____
Depression	no	yes	_____
Erectile dysfunction	no	yes	_____
Cancer / Type	no	yes	_____
Thyroid problem(s)	no	yes	_____
Epilepsy	no	yes	_____
Anemia	no	yes	_____
Fractures	no	yes	_____
HIV	no	yes	_____
Any other diseases	no	yes	_____

_____ __

_____ __

ALLERGIES: ARE YOU ALLERGIC TO OR INTOLERANT OF:

			Reaction
Penicillin	no	yes	_____
Sulfa	no	yes	_____
Aspirin	no	yes	_____
Codeine	no	yes	_____

Any other drugs: _____

_____

Environmental Allergies: _____

_____

COMPLICATIONS

Tonsillectomy	no	yes	_____
Appendix operation	no	yes	_____
Hernia operation	no	yes	_____
Stomach operation	no	yes	_____
Gall bladder operation	no	yes	_____
Thyroid operation	no	yes	_____
Prostate operation	no	yes	_____
Hysterectomy	no	yes	_____
Removal of ovaries	no	yes	_____
Cesarean section	no	yes	_____
Breast biopsy	no	yes	_____

Any other operations: _____

_____

_____

DIABETES:

			Date
Eye problems laser treatment	no	yes	_____
Kidney problems	no	yes	_____
Nerve damage	no	yes	_____
Gastroparesis	no	yes	_____
Peripheral arterial disease (blockage of blood vessels	no	yes	_____
Foot ulcers:	no	yes	_____

DO YOU TAKE MEDICATIONS REGULARLY YES NO

Names, Dose, Schedule

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History	If Living Age	If Living Health	If Deceased Age	Cause of Death
Father				
Mother				
Brother or Sister 1				
Brother or Sister 2				
Brother or Sister 3				
Brother or Sister 4				
Husband or Wife				
Son or Daughter 1				
Son or Daughter 2				
Son or Daughter 3				
Son or Daughter 4				

Has any **blood** relative ever had:			Who	Approx. Age at onset
Cancer	no	yes		
Tuberculosis	no	yes		
Diabetes Type 1 or 2	no	yes		
High Blood Pressure	no	yes		
Stroke	no	yes		
Osteoporosis	no	yes		
Heart Trouble	no	yes		
Thyroid Disorder	no	yes		
over active	no	yes		
under active	no	yes		
Depression	no	yes		
Kidney Stones	no	yes		
High Cholesterol	no	yes		

HEALTH… Excellent / Good / Fair / Poor

NOTE: This is a confidential record of your medical history. It will be kept in this office and not released without your permission.

SYMPTOMS/PROBLEMS:

Do you now have on a regular basis:

Cough no yes _____

Sputum (phlegm) no yes _____

Shortness of breath no yes _____

Chest pain no yes _____

Sharp Dull Achy Other_____ Associated with activity? ____

Skipped or rapid heartbeat no yes _____

Angina_____ no yes _____

Use of nitroglycerin_____ no yes _____

Appetite: excellent good fair poor

Are you a nighttime eater? no yes _____

Nausea no yes _____

Vomiting no yes _____

Diarrhea no yes _____

Constipation no yes _____

Abdominal pain no yes _____

Gas pain no yes _____

Heartburn no yes _____

Blood in stools no yes _____

Headache tension /migraine/cluster/sinus) no yes _____

Frequency? _____

Light headed no yes _____

Dizziness (vertigo/room spinning) no yes _____

Fainting spells no yes _____

Seizures no yes _____

Muscle weakness (where?) no yes _____

Numbness, tingling (where?) no yes _____

How often?_____

Loss of vision no yes _____

Blurred vision no yes _____

Impaired vision near-sighted ☐ far-sighted ☐

Do you wear glasses? no yes _____

Do you wear contact lenses? no yes _____

Do you urinate more than you feel you should? no yes _____

Do you have difficulty urinating? no yes _____

Slow starting? no yes _____

Dribbling? no yes _____

Leak urine? no yes _____

Do you bleed easily? no yes _____

Do you bruise easily? no yes _____

Fever (Temp > 101) no yes _____

Weight loss or gain no yes _____

Intentional no yes _____

lack of energy & pep no yes _____

Do you feel tired all the time? no yes _____

Do you sleep well? no yes _____

Snoring? no yes _____

Stop breathing? no yes _____

Pain in legs with walking no yes _____

Difficulty swallowing no yes _____

Change in voice no yes _____

YOUR SEX LIFE IS:

Excellent ☐ Satisfactory ☐ Unsatisfactory ☐
Poor ☐ None ☐

ALCOHOLIC BEVERAGES: never rarely moderate heavily

beer ☐

wine ☐ number of years_____

other ☐ avg number of drinks/week_____

What do you consider yourself:

non drinker ☐ social occas. drinker ☐

moderate drinker ☐ heavy drinker ☐

alcoholic ☐

AVERAGE AMOUNT OF SMOKING THROUGHOUT LIFE:

cigarettes: _____packs per day number of years_____ever quit? If so, when?_____

_____restart?

cigars_____ pipe_____ chewing tobacco_____

WOMEN ONLY

DO YOU TAKE BIRTH CONTROL PILLS? yes no

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? Yes no NUMBER OF YEARS?_____

MENSTRUAL HISTORY?

age at onset_____

regular? ____yes ____no

cycle:_____ days (from start to start)

usual duration: _____days heavy____ medium____ light____

pains or cramps: ____yes ____no

date of last period_____

AGE & YEAR IN WHICH PERIODS STOPPED

permanently - menopause (if applicable)_____

age_____ year_____

DATE OF LAST PAP SMEAR?_____ result?_____

DATE OF LAST MAMMOGRAM? _____ result?_____

PREGNANCIES

How many pregnancies?_____

How many children born alive? _____

How many stillborn? _____

How many prematures? _____

How many cesarean sections? _____

How many miscarriages? _____

How many abortions? _____

Any complications with pregnancies? _____

Gestational diabetes? _____

Last tetanus booster_____ Hep. B vaccine_____

Flu vaccine_____ Pneumovax_____

NAMES OF PHYSICIANS THAT ARE FAMILIAR WITH YOUR MEDICAL CONDITION:

Name Town

Primary Care_____

OB/GYN_____

OPTHAL/OPT_____

ORTHO_____

CARDIAC_____

OTHER_____

OVER