4761 Main Street
Bridgeport, CT 06606
Phone: (203) 816-0326
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Patient Intake Form

Name: ______________________ Birthdate: ____________

Male Female (circle one)

Address City State Zip Code

Home: Cell: Work:

Email ______________________

Emergency Contact Relation:

Phone: ______________________

How did you hear about us?

Who is your Primary Care Physician?

Name: ______________________

Address City State Zip Code

Phone:

Name of Insurance Carrier ______________________

Name of Policy Holder ______________________ Relation to Policy Holder ______________________

Program Name ______________________

ID No. ______________________ Group/Policy No. ______________________

Occupation ______________________

Employer/School ______________________

Phone:

What is the reason for your visit?

When did this begin? ______
What is the current status of the concern? ______
What is it like? (please be descriptive) ______

How bad is it? (pain on scale 1-10, 10 worst possible) ______
Does anything make it better or worse? ______

Has anything else accompanied this concern? ______

Has any treatment begun? If so, what?

Medical History
Please list all medications you are currently taking.

Please list all herbs/vitamins you are currently taking.

Please list all known allergies. None known (circle if applicable)

Please list all major surgeries and hospitalizations.

Family Medical History
Please list all major illnesses in your family and relation. (i.e. cancer, heart disease, diabetes . . .)

Have you ever experienced, been diagnosed with or received treatment for the following?
(please circle all that apply)

General	**Breasts**	**Urinary**	**HEENT**
Weakness	Lumps	Frequent urination	Headache
Fatigue	Pain or discomfort	Urination at night	Dizziness
Fever	Nipple discharge	Urgency	Fainting
Skin	Self Breast Exams	Pain or discomfort	Glasses or contacts
Rashes	**Respiratory**	Blood in urine	Eye pain
Lumps	Coughing blood	Kidney stones	Blurry vision
Itching	Shortness of breath	Incontinence	Cataracts
Changes in hair or nails	Difficulty breathing	Dribbling	Glaucoma
Gastrointestinal	Wheezing	Decreased force	Ringing in the ears
Difficulty swallowing	Asthma	**Peripheral Vascular**	Vertigo
Heartburn	Emphysema	Leg cramps	Ear discharge
Change in appetite	Pneumonia	Varicose veins	Loss of hearing
Nausea	Tuberculosis	Blood clots	Frequent sinus troubles
Blood in stools	**Cardiovascular**	**Musculoskeletal**	Hay fever
Hemmorrhoids	High blood pressure	Muscle or joint pain	Bleeding gums
Constipation	Rheumatic Fever	Stiffness	Dry mouth
Diarrhea	Heart murmurs	Gout	Frequent sore throats
Abdominal pain	Chest pain	**Neurologic**	Hoarseness
Jaundice	Palpitations	Fainting	**Endocrine**
Hepatitis	Shortness of breath	Seizures	Heat or cold intolerances
Hematologic	Edema	Weakness	Excessive sweating
Anemia	**Neck**	Paralysis	Excessive thirst
Easy bruising	Lumps	Numbness or loss of sensation	Nervousness
Transfusions	Goiter	Tingling	Mood changes
		Tremors	Memory change

What do you do in your spare time? Hobbies? ______________________________

How much sleep do you get each night? Quality? ______________________________

How much exercise do you get? min/day? What activities? ______________________________

Do you smoke? Yes/No If yes, packs/day? ______________________________

Do you consume alcohol? Yes/No Type? ______________________________

Diet Recall: (please list what you typically eat for the following meals)

Breakfast ______________________________

Snack ______________________________

Lunch ______________________________

Snack ______________________________

Dinner ______________________________

Dessert ______________________________

Fluids (glasses/day) ______________________________