

Please circle answers in indicated fields after printing

**PATIENT INFORMATION**

**101 Airport Road  
Westerly, RI 02891**

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**489 Rt. 184, Suite 110  
Groton, CT 06340**

<b>Name:</b> _____		<b>Date of Birth:</b> _____	
<b>Primary Language:</b> _____		<b>Gender:</b> <b>Male or Female</b>	
Phone Number: _____		Height: _____ Weight: _____	
<b>Reason for visit:</b> _____		Primary Care Doctor: _____	
Cardiologist: _____		Pulmonologist: _____	
<b>Ethnicity (Please circle one):</b>			
Hispanic / Latino		Not Hispanic or Latino	Patient Refusal
<b>Race (Please circle one):</b>		<b>Please indicate (circle) your marital status:</b>	
American Indian/ Alaskan Native		Single	Fiancé
Asian		Married	Non-Declared
Black or African American		Widowed	Legally Separated
Native Hawaiian or other Pacific Islander		Divorced	Life Partner
White / Caucasian		Other	
Patient Refusal			
<b>Are you a smoker:</b> Yes or No		<b>Do you consume alcohol:</b> Yes or No	
If yes: amount per day: _____		If yes: amount per day: _____	
<b>Former smoker:</b> Yes or No		<b>Recreational Drug Use:</b> Yes or No	
If yes: date quit: _____		If yes: type: _____	
<b>Do you have a healthcare proxy / durable power of attorney for health care or conservator?</b>			
Yes / No, If so who? _____			

**Do you have allergies and / or sensitivities:** Yes or No, If yes, please list below (i.e. Latex, medication, tape, contrast dye, iodine, food, environmental):

Allergy	Reaction

**List of Medications (include dose, frequency, and all non-prescription drugs):**

If all medications will not fit in this area, PLEASE PROVIDE A SEPERATE LIST OF ALL MEDICATIONS

Medication	Dosage	Frequency

**List any Surgical Procedures:**

Surgery	Date of Surgery

Have you had a problem with anesthesia? Yes or No

If yes, please explain: \_\_\_\_\_

Have you had a blood relative had a reaction to anesthesia called malignant hyperthermia? Yes or No

## Health History (please circle yes or no to the general health questions below):

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Neurological Problems:

CVA / Stroke	Y / N Date:
TIA / Mini Stroke	Y / N Date:
Seizures	Y / N Most Recent:
Restless Leg Syndrome	Y / N
Other	Specify:

### Pulmonary Problems:

COPD / Emphysema	Y / N
Shortness of Breath	Y / N
Sleep Apnea	Y / N
CPAP / BIPAP Machine	Y / N Settings:
Asthma	Y / N
Use Oxygen	Y / N Liters:
Recent Cold	Y / N
Other	Specify:

### Cardiac Problems:

High Blood Pressure	Y / N
Elevated Cholesterol	Y / N
Angina (Heart Chest Pain)	Y / N
Coronary Artery Disease	Y / N
Angioplasty Stents	Y / N
Heart Attack	Y / N When:
Swelling in Legs / Feet / PVD	Y / N
Irregular Heart Beat	Y / N
Congestive Heart Failure	Y / N
Heart Murmur	Y / N
Leaky Valve	Y / N
Valve Prolapsed	Y / N
Blood Clot in Leg	Y / N
Pacemaker	Y / N When: _____ Company: _____
Defibrillator	Y / N When: _____ Company: _____
Other	Specify:

### Genitourinary Problems:

Prostate Problems	Y / N
Peritoneal Dialysis	Y / N
Hemodialysis	Y / N Days:
Other	Specify:

### Gastrointestinal Problems:

Hepatitis	Y / N Type:
Heartburn	Y / N
Liver Disease	Y / N
Peptic Ulcer	Y / N
Other	Specify:

### Endocrine Problems:

Thyroid Problems	Y / N
Diabetes	Y / N How Long?
Other	Specify:

### Musculoskeletal Problems

Disk Problems	Y / N
Chronic Pain Syndrome	Y / N
Cane / Walker / Wheelchair	Y / N
Arthritis	Y / N

### Hematological (Blood) Problems:

Anemia	Y / N
Bleeding Problems	Y / N
Clotting Problems	Y / N
Other	Specify:

### Psychiatric History:

Depression	Y / N
Bipolar	Y / N
ADD	Y / N
Panic / Anxiety Attacks	Y / N
Schizophrenia	Y / N
Mentally Challenged	Y / N
Other	Specify:

### Infectious Disease:

Recent Exposure to Communicable Disease(s)	Y / N
HIV Positive	Y / N
Infection Called MRSA	Y / N
Infection Called C DIFF	Y / N
Infection Called VRE	Y / N
Have RECENTLY had a Fever, Night Sweats, Cough, Bloody Sputum or Fatigue for MORE than 3 WEEKS	Y / N
Other	Specify:

### Eye, Ear, Nose, Throat Problems:

Glasses	Y / N
Legally Blind	Y / N
Hearing Aids	Y / N – R or L Ear
Sign Language	Y / N
Contact Lenses	Y / N
Prosthetic Eye	Y / N – R or L Ear
Dentures	Y / N
Need Interpreter	Y / N
Other	Specify:

### Female ONLY:

Pregnant	Y / N Due Date:
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How did you learn about the practice? \_\_\_\_\_

Have any family member been to our office? If so, whom and relationship to patient?  
\_\_\_\_\_

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions I have made in completion of this form.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Received by: \_\_\_\_\_

Date: \_\_\_\_\_