Hartford HealthCare Medical Group

GENERAL PATIENT INTAKE FORM

NAME: _____ TODAY'S DATE: _____
FIRST MIDDLE LAST

AGE: _____ RACE: _____ D.O.B.: _____

NAME OF PROVIDER WHO REFERRED YOU TO OUR PRACTICE:
_____

NAME OF YOUR PRIMARY CARE PROVIDER:
_____

Symptoms/main concern:
_____

REVIEW OF SYSTEMS
(Please circle current symptoms)

General
Weight Gain
Weight Loss
Night Sweats
Fever
Fatigue
Falls

Eyes:
Blurred/impaired vision
Dry Eyes
Double vision

Ears,nose,throat:
Sore throat
Voice change
Difficulty swallowing
Choking on foods
Choking on liquids
Swollen or enlarged Neck
Tender neck
Excessive thirst

Cardiovascular:
Chest pains/discomfort
Palpitations/racing heart beat
Swelling of feet, ankles or hands
Cold/pale feet

Respiratory:
Shortness of breath
Asthma or wheezing
Snoring
Gasping for breath overnight

Gastrointestinal:
Loss of appetite
Increase in appetite
Change in bowel movements
Nausea
Vomiting
Diarrhea/loose stools
Constipation
Stomach pain
Heartburn

Genitourinary:
Frequent urination
Burning or painful urination
Yeast infections
Kidney stones
Sexual difficulty
Infertility

Musculoskeletal:
Joint stiffness or swelling
Weakness of muscles/joints
Muscle pain or cramps
Back pain
Leg pain with walking
Leg swelling
Limb weakness

Endocrine:
Heat Intolerance
Cold intolerance

Skin:
Rash
Itching skin
Non-healing sores
Excessive Hair Growth
Hair loss
Dry skin
Darkening of skin
Brittle hair
Brittle nails
Discharge from nipples

Psychiatric:
Depression
Anxiety
Sleep problems
Suicidal thoughts
Thoughts of harming others

Neurological:
Syncope/Passing out
Headaches
Lightheaded
Dizziness
Convulsions or seizures
Numbness or tingling
Tremors

Name:_____DOB:_____

PAST MEDICAL HISTORY (Please check the appropriate box if you have ever had the following condition.)

	Yes	Year		Yes	Year		Yes	Year
Diabetes			Laser surgery for diabetic retinopathy			Osteoporosis		
High blood pressure			Thyroid disease			fractures		
High cholesterol			Goiter/thyroid nodules			Cancer Type?		
Heart attack			Radiation therapy to head/neck			Seizures/epilepsy		
Stroke			COPD			depression		
Cataract surgery			Sleep apnea CPAP use?			Kidney stones		
Other illnesses:			Other illnesses:			Other illnesses:		

SURGERIES

SURGERY	HOSPITAL	YEAR

MEDICATIONS (Please list ALL medications including over the counter, herbs, supplements, vitamin, creams)

NAME OF DRUG	STRENGTH	HOW MANY PULLS AND HOW OFTEN?	WHAT YEAR DID YOU START TAKING IT?

Name:_____DOB:_____

ALLERGIES (MEDICATIONS, ENVIRONMENT, FOOD) **AND REACTION** (I.E. ANAPHYLAXIS, HIVES)

_____

_____

_____

FOR FEMALES

Do you take birth control? (pills, arm implantable devices, IUD, patch)? Y or N
If no, have you ever been on birth control? Y or N
If yes, for many years? _____

Menstrual history:
Age at first period:_____Regular? Y or N Length of period:_____ days (from start to start)
Usual duration: _____days ◊ heavy ◊ medium ◊ light
Pains or cramps: ____yes ____no
If you are in menopause, when did this occur? Age_____ OR Year_____
◊ Natural menopause OR ◊ Surgical menopause

Pregnancies
How many pregnancies?____How many children born alive? ____

SOCIAL HISTORY

Marital status:
◊ Married ◊ Single ◊ Widowed ◊ Divorced

Children:
Y or N If yes, how many? _____

Education: (Circle highest level)
Grade school, junior high school, high school, college, graduate school

Habits:
Smoking: Y or N
If yes, how many packs/day? _____How many years? _____

Alcohol: ◊ Never ◊ Socially/rarely ◊ <3 drinks a day/<7 drinks a week ◊ >3 drinks a day/>7 drinks a week

Recreational drugs: ◊ Never ◊ Occasionally ◊ Frequently
If yes, what kind? _____

Current occupation: _____ ◊ Unemployed ◊ Retired

Name:_____DOB:_____

FAMILY HISTORY

Relative	If Living: Age, 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	Age at onset
Cancer	no	yes		
High Cholesterol	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		
Depression	no	yes		
Kidney Stones	no	yes		

Please note, you may be asked to complete a secondary questionnaire during the visit specific to your condition.

HHCMG Endocrinology & Diabetes Center

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