

CTHerniaCenter

2200 Whitney Avenue, Suite 220 Hamden, CT 06518

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

M F

Address:

City:

State:

Zip:

Age:

DOB:

Home
Phone:

Work
Phone:

Cell
Phone:

Social
Security#

Marital status:

Single

Married

Partnered

Divorced

Widowed

Email:

Emergency Contact:

Relationship:

Emergency Contact Phone#:

Emergency Contact Cell#:

Primary Care Physician:

Referring Physician:

Employer:

Occupation:

Is this condition work related? Yes No

Worker's Comp Carrier:

Claim#:

Are you a Full Time Student? Yes No

Name of School/University:

INSURANCE INFORMATION

Primary Insurance Carrier:

Policy Number:

Subscriber Name:

Address:

City:

State:

Zip:

Subscriber Date of Birth:

Relation to Insured:

Secondary Insurance Carrier:

Policy Number:

Subscriber Name:

Address:

City:

State:

Zip:

Subscriber Date of Birth:

Relation to Insured:

Tertiary Insurance Carrier:

Policy Number:

Subscriber Name:

Address:

City:

State:

Zip:

Subscriber Date of Birth:

Relation to Insured:

PAST MEDICAL HISTORY

Past Medical Illnesses: List any medical problems that other doctors have diagnosed

Heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Health Problems: _____
GI Tract <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

FAMILY HISTORY

Age	<i>Please List: Family Illnesses</i>	
Father		
Mother		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F	
Children	<input type="checkbox"/> M <input type="checkbox"/> F	

PREVIOUS SURGERY

Year	Procedure	Surgeon	Hospital

PREFERRED PHARMACIES

Name of Pharmacy:	Pharmacy Address:	Pharmacy Phone#:
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MEDICATIONS

Do you take Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kind and how often? _____				
Name the Drug	Strength	Frequency	Name the Drug	Strength	Frequency

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL			
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind, how much per day or week? _____		
Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of years as a smoker? _____	

SYSTEMS REVIEW

<i>Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.</i>				
<input type="checkbox"/> Skin	<input type="checkbox"/> Ears	<input type="checkbox"/> Heart	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Nose	<input type="checkbox"/> Back	<input type="checkbox"/> Bladder	<input type="checkbox"/> Energy level
				<input type="checkbox"/> Weight <input type="checkbox"/> Ability to sleep

What is your reason for today's visit? _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR MY CARE AND PAYMENT OF MEDICAL BENEFITS TO CIARDIELLO & BONADIES SURGERY GROUP, P.C.:

Patients Signature: _____ Date: _____