Dr. Vaughn Bowman
1177 Summer St, Stamford CT 06905
Phone: 203 750-0853

Adult Patient Profile:

Please complete the following questionnaire as thoroughly as possible to aid your physicians in their diagnosis and treatment. This will become a part of your confidential medical record and will not be released unless you have authorized for us to do so. PLEASE PRINT CLEARLY.

Last name: _____ First Name: _____ Middle initial:_____

Date of birth: _____ Age: _____ Gender (sex): _____ SSN: _____

(number, street, apt number, city, state, and zip/postal code)

Address:_____

Home Phone: (____) _____ Employer: _____Work Phone: (___)_____

Emergency Contact:_____ Relation:_____ Phone:(____)_____

How did you hear about our office (Is there someone we can thank?) _____

Insured Patient's Information: Company Name _____ Policy Number _____

(Fill out if different from above..(you are not the primary name on the policy)) Insured Person's Date of Birth____

Insured Patient's Name_____ Employer_____ Social Security _____

Present Health Concerns (in order of importance): Duration:

1. _____ _____
2. _____ _____
3. _____ _____

Social History (please circle, or complete if applicable):

Single Married Significant other Name of husband/ wife/ partner:_____

Your Occupation: _____ Your Education:_____

Children (names and ages):_____

_____

What level of change to your living habits are you willing to make to improve your health? (circle one):

Whatever it takes Significant change Some change No change

Known Allergies [drugs, food, environmental (grass, pollen, etc.)]: _____

_____

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Vitamins/ Herbs/ Supplements Currently Taking:

Name/ Type	Reason for Taking	Dose/ day (mg/etc)	For how long	Who prescribed

Current Medications (prescription and over the counter) :

Name of drug	Reason for drug	Dose (mg/etc)	For how long	Prescribing Dr.

Regular Exercise (complete if applicable) :

Type(s) (running/weights/dance/etc.)	Time per session (min/hours/etc.)	Frequency (daily/weekly)	Practiced for how long (weeks/months/years)

Sleep Habits:

How many Hours/night: _____ Do you wake refreshed? ____ If not why? _____

Do you have problems (circle): Falling asleep Staying Asleep Waking up

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Average energy level per week (circle one):

1 2 3 4 5 6 7 8 9 **10**
(lowest) **(highest)**

Average stress level per week (circle one):

1 2 3 4 5 6 7 8 9 **10**
(lowest) **(highest)**

How do you cope with stress? _____

Do you talk to anyone about your problems? _____ **Who?** _____

Who else might you confide in, or seek advice from? _____

What are some things you do for fun and how often? _____

_____

List any chemicals, fumes, dusts etc., that you are or have been repeatedly exposed to: _____

_____

Diet history (include any liquids tea, coffee, etc., in description; in table below, list number of servings):

What was breakfast yesterday? _____
What was lunch yesterday? _____
What was dinner yesterday? _____
List snacks you had yesterday? _____
How many glasses of plain water do you drink per day? _____ **filtered** **tap** **distilled** **well water**
Any special diet restrictions? _____

	Never	**Occasionally**	**Weekly**	**Daily**
Red meat				
Fish				
Chicken				
Fresh fruits				
Vegetables				
Dairy products				
Whole grains				
Sweets				

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Medical / Health History:

Primary Care Doctor / Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Office Name: _____ Doctor's phone number: (____) _____

Doctors full address: _____

Other Current Provider(s) name: Type: For what health reason: Phone:

Date of last full physical exam: _____ Results: normal, other _____

Date of last urine test: _____ Results: normal, other _____

Date of last blood work: _____ Results: normal, other _____

Date of last PAP/ pelvic exam (females): _____ Results: _____

Date of last mammogram (females over 40): _____ Findings: _____

Are you pregnant (females)? _____ If so, how far along are you? _____

Date of last prostate exam (males): _____ Results: _____

How would you describe your general health? _____

Outpatient Procedures / Hospitalizations (surgeries/ special diagnostic studies):

Type (of surgery/study)	Date	Reason for procedure/ admission	Outcome / Results

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Major Illnesses/ emotional or physical trauma/ accidents (if not already listed):

Type	Date	Treatment received	Outcome

Eliminations (please complete):

Bowel movement habits

Frequency: (how often)	
Color: (black, brown, yellow, green, white)	
Consistency: (hard, formed, soft, watery)	
Any mucus or blood? (which)	
Does it pass easily? (any straining involved)	

Urine habits

Frequency: (how may times per 24 hour period)	
Color: (dark yellow, light yellow, green, colorless)	
Character: (clear, cloudy, concentrated, dilute)	
Any blood or sediment? (which)	
Any pain, incontinence, difficulty with stream?	

Personal Habits (check or describe in the following boxes):

	Tobacco	Alcohol	Caffeine	Recreational drugs
Currently use:				
Previously used:				
Never used:				
How much/ many: (per day/week/ month/ etc.)				
Specify type: (filtered/not; beer/ wine/ mixed drinks; tea/coffee/espresso)				
For how long: (months/years)				
Date Quit:				

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Review of Systems (check if you've had any of the following):

___anemia
___blood diseases
___fatigue (affecting daily living)
___dizziness (more than 5 seconds)
___frequent headaches
___loss of hearing
___ringing in ears (more than 5 sec)
___loss of vision
___eye pain
___frequent sore throats
___lasting numbness
___lasting weakness
___lasting tingling
___nervousness/ depression
___skin problems
___brittle nails
___hair loss
___allergies
___frequent sinus infections
___cancer
___asthma
___difficulty breathing
___chronic bronchitis
___tuberculosis
___stomach ulcers
___constipation
___diarrhea (infectious)
___diarrhea (bloody)
___lasting nausea
___recurrent vomiting
___chest pain
___heart disease
___heart failure
___irregular heart beat
___hemorrhoids
___easy bruising
___frequent nosebleeds
___varicose veins
___poor circulation
___stroke
___kidney failure
___kidney infection
___kidney stones
___sexually transmitted diseases
___thyroid disorder
___diabetes
___swelling of ankles
___liver disease
___hepatitis
___arthritis
___neck pain / stiffness
___low back pain / stiffness
___bursitis
___hot and swollen joints
___prostate enlargement
___cramps /backache (females)
___excessive menstrual flow
___hot flushes
___irregular cycles
___fibrocystic breasts

Family History (Using the following key, designate which family members have had the following. List type where parenthesis are present):

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

condition	whom	condition	whom	condition	whom
Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer ( )		Mental disorder	
Anemia		Cancer ( )		Obesity	
Arthritis (Rheumatoid)		Epilepsy		Stroke	
Arthritis (Osteo)		Disease		Thyroid disorders	
Auto Immune disease		Hepatitis		Other: ( )	
Bleeding tendency		High Blood Pressure		Other: ( )	

Thank you for filling out this lengthy form. Is there anything else you would like us to know? _____

_____