# PATIENT INFORMATION

**101 Airport Road**
**Westerly, RI 02891**

**Daniel R. Gaccione, M.D.**
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**489 Rt. 184, Suite 110**
**Groton, CT 06340**

**Name**: _____ **Date of Birth**: _____
**Primary Language**: _____ **Gender:** **Male or Female**
Phone Number: _____ Height: _____ Weight: _____
**Reason for visit**: _____ Primary Care Doctor: _____
Cardiologist: _____ Pulmonologist: _____

**Occupation**: _____

**Ethnicity (Please circle one)**:

Hispanic / Latino | Not Hispanic or Latino | Patient Refusal

| **Race (Please circle one)**: | **Please indicate (circle) your marital status**: | |
|---|---|---|
| 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 | **Do you have children? Ages:** _____ | |

| | |
|---|---|
| **Are you a smoker:** Yes or No | **Do you consume alcohol:** Yes or No |
| If yes: amount per day: _____ | If yes: amount per day: _____ |
| **Former smoker:** Yes or No | **Recreational Drug Use:** Yes or No |
| If yes: date quit: _____ | If yes: type: _____ |

**Do you have a healthcare proxy / durable power of attorney for health care or conservator?**
**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)**:

| 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 or 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: |

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: _____