PATIENT INFORMATION

Christopher M. Hutchins, M.D. **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: _____

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		

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 (please circle), 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

Do you have an advanced care plan / living will: Yes or No (Please circle)

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

Medication	Dosage	Frequency

List any Surgical Procedures (include dose, frequency, and all non-prescription drugs):

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:

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: _____