

Dr. Vaughn Bowman
6 Rudolf LN, Norwalk, CT 06851
Phone: 203 750-0853 Fax: 203
750-0854

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 _____

If insured's name on card is different than your own please fill out the following:

Insured Person's Date of Birth _____ Insured'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.)]: _____

Dr. Vaughn Bowman
6 Rudolf Lane, Norwalk CT 06581
Phone: 203-750-0853 Fax: 203-750-0854

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

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				

4.

Dr. Vaughn Bowman
6 Rudolf Lane,
Norwalk CT 06851
Phone: (203) 750-0853
Fax: (203) 750-0854

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:**

Other <u>Current</u> 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

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

5.

Dr. Vaughn Bowman
 6 Rudolf Lane, Norwalk
 CT 06851 Phone: (203) 750-0853

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 many 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

	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:				

6.

Dr. Vaughn Bowman
6 Rudolf Lane, Norwalk CT 06851
Phone: (203) 750-0853 Fax: (203) 750-0854

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

- | | | |
|--|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> asthma | <input type="checkbox"/> kidney failure |
| <input type="checkbox"/> blood diseases | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> kidney infection |
| <input type="checkbox"/> fatigue (affecting daily living) | <input type="checkbox"/> chronic bronchitis | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> dizziness (more than 5 seconds) | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> frequent headaches | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> loss of hearing | <input type="checkbox"/> constipation | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> ringing in ears (more than 5 sec) | <input type="checkbox"/> diarrhea (infectious) | <input type="checkbox"/> swelling of ankles |
| <input type="checkbox"/> loss of vision | <input type="checkbox"/> diarrhea (bloody) | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> eye pain | <input type="checkbox"/> lasting nausea | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> recurrent vomiting | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> lasting numbness | <input type="checkbox"/> chest pain | <input type="checkbox"/> neck pain / stiffness |
| <input type="checkbox"/> lasting weakness | <input type="checkbox"/> heart disease | <input type="checkbox"/> low back pain / stiffness |
| <input type="checkbox"/> lasting tingling | <input type="checkbox"/> heart failure | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> nervousness/ depression | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> hot and swollen joints |
| <input type="checkbox"/> skin problems | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> prostate enlargement |
| <input type="checkbox"/> brittle nails | <input type="checkbox"/> easy bruising | <input type="checkbox"/> cramps /backache (females) |
| <input type="checkbox"/> hair loss | <input type="checkbox"/> frequent nosebleeds | <input type="checkbox"/> excessive menstrual flow |
| <input type="checkbox"/> allergies | <input type="checkbox"/> varicose veins | <input type="checkbox"/> hot flushes |
| <input type="checkbox"/> frequent sinus infections | <input type="checkbox"/> poor circulation | <input type="checkbox"/> irregular cycles |
| <input type="checkbox"/> cancer | <input type="checkbox"/> stroke | <input type="checkbox"/> 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: ()	

Anything else you want us to know about you? _____

THANK YOU for your time and patience in filling out this rather lengthy form!

