

NORTHEAST MEDICAL GROUP ~ SHORELINE INTERNAL MEDICINE ~ 203-453-4444

Mary J. Scheimann, MD * Edward J. Dill, MD * Jodi E. Indes, MD * Fraser Lawrence, MD

CONFIDENTIAL MEDICAL INFORMATION SHEET

(PLEASE FILL IN ALL SPACES THAT APPLY – THIS WILL BE REVIEWED WITH YOU BY YOUR DOCTOR)

NAME _____ BIRTHDATE ___/___/___ AGE _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ TELEPHONE (HOME) _____ (CELL) _____ (WORK) _____

EMERGENCY CONTACT & RELATION _____ TELEPHONE _____

MAIN REASON FOR TODAY'S VISIT _____ TODAY'S DATE _____

OTHER CURRENT MEDICAL PROBLEMS

PAST MEDICAL PROBLEMS / HOSPITALIZATIONS

SURGICAL HISTORY (Date/Type/Surgeon/Hosp)

SOCIAL HISTORY SMOKER? _____

How many cigarettes per day? _____

How many years have you smoked? _____

Are you ready to quit? YES NO

How much alcohol do you consume per day? ___ Week? ___ Month? ___ Any drug use? _____

MEDICATION ALLERGIES _____ ALLERGY TO SHELLFISH? _____

DATE OF LAST MENSES _____ ARE YOU PREGNANT OR TRYING TO CONCEIVE? _____

CURRENT DAILY MEDICATION & DOSAGE (Including Over the Counter Meds / BCP's / Vitamins & Insulin)

MEDICATION TAKEN FREQUENTLY ON AS-NEEDED BASIS DO YOU TAKE ASPIRIN DAILY? _____

PHARMACY/TOWN _____

HOSPITAL OF MOST RECENT MEDICAL RECORD _____ GENERAL SURGEON _____

GYN _____ EYE PHYSICIAN _____ OTHER _____