GREENWICH MEDICINE, LLC
38 Lake Avenue
Greenwich, CT 06830

MEDICAL HISTORY (part I)

www.GreenwichMedicine.com

Today's Date:_____

First name _____ M.I.___ Last name _____

PRIMARY CARE PROVIDER

Name of Physician _____

Address _____

City _____ State _____ Zip code _____

Phone _____

PSYCHOLOGIST OR THERAPIST

Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____

Date of last visit:_____ Frequency of visits:_____

CURRENT / FORMER PSYCHIATRIST

Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____

Date of last visit:_____ Frequency of visits:_____

This information is for our records only and any communication with the above named providers will only occur with your signed authorization.

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MEDICAL HISTORY (part II)

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CURRENT MEDICATIONS (including OTC drugs, herbal remedies and nutritional supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES (to medications or foods) _____

SPECIALISTS SEEN (at any point in the past)

___allergist	___infectious disease specialist	OTHER THAN ROUTINE
___endocrinologist	___nephrologist	___OB/GYN
___gastroenterologist	___dermatologist	___opthalmologist
___hematologist	___ENT	___internist
___neurosurgeon	___urologist	
___cardiologist	___rheumatologist	___OTHER_____
___cardiothoracic surgeon	___oral surgeon	
___general surgeon	___pulmonologist	
___plastic surgeon	___oncologist	
___pain specialist	___neurologist	
___orthopedic surgeon	___sleep specialist	

MEDICAL CONDITIONS (please list all medical conditions that you have been evaluated for, diagnosed with, and/or treated for, both current and past):

_____ _____ _____

_____ _____ _____

_____

HOSPITALIZATIONS, SURGERIES, & EMERGENCY ROOM VISITS

_____ _____ _____

_____ _____ _____

Have you ever had:

___seizures	___heart palpitations	___fracture or severe injury
___blackouts	___chest pain	___head injury/concussion
___fainting spells	___shortness of breath/asthma	___NONE OF THE ABOVE