PATIENT INFORMATION

Name:_____**Date of Birth**_____.

Address:_____**City:**_____**State:**_____ **zip:**_____

Phone: H:_____**Wk:**_____**Cell:**_____

Email Address (please print) : _____

Male Female No. of Children:____ **Occupation:**_____**Married**

Single Divorced Widow

Employer:_____**Address:**_____

Name of Spouse:_____

Person Responsible for account: _____

EMAIL ADDRESS:

INSURANCE INFORMATION
(*Please give copy of insurance card to receptionist.)*

*PATIENTS NAME:*_____

Insured's Name:_____**DOB:**_____**SEX:**_____

Insured's Address:_____

Employer's Name:_____

MAY RELEASE PROTECTED HEALTH INFORMATION

TO:(names):_____

Referred by: _____

Henry C. Sobo, M.D.
111 High Ridge Road
Stamford, CT 06905
203-348-88058

NAME: _____

PRIMARY REASON FOR VISIT: _____

Healthy Lifestyle:

Do you smoke cigarettes or cigars?____ How many per day? _____
Do you drink alcohol? Never____ Occasionally____Every Week____More than 2x's week____ Daily____
Do you use any other drugs? (type and frequency) _____
Do you exercise? ____ If so, what and how often:____

Family Medical History (mother, father, siblings, or maternal or paternal grandparents)

Heart Disease____	Diabetes____	Bowel Dis. (type)____
High Blood Pressure___	Obesity____	Kidney Dis.____
Stroke____	Arthritis (type)	Blood Disorder____
Cancer (type)____	Psychiatric Dis.____	Neurologic Dis.____
Genetic Disease____	Parental Drug Abuse____	Sinus Problems _____

SYMPTOM SURVEY: METABOLIC SCREENING QUESTIONNAIRE
POINT SCALE: ***1=MILD 2=MODERATE 3=SEVERE***

HEAD
Headaches____
Faintness____
Dizziness____
Insomnia____
Sinus Problem _____

SKIN
Acne____
Hives, rash, dry skin____
Hair loss____
Flushing, hot flashes____
Excessive Sweating____

EYES
Watery or Itchy____
Swollen, red, sticky____
Bags, dark circles____
Blurred___
Tunnel Vision_____

MOUTH/THROAT
Chronic Coughing____
Gagging, freq. Clearing____
Sore Throat____
Hoarseness____
Sinus Congestion____

EARS
Itchy Ears____
Earaches, Ear Infection_
Drainage from ear____
Ringing in Ears____
Hearing Loss____

ENERGY & ACTIVITY
Sluggishness____
Apathy____Lethargy____
Restlessness____
Hyperactivity____
Fatigue____

HEART
Irregular Heartbeat____
Skipped Heartbeat____
Rapid or pounding HB__
Chest Pain____

MIND
Poor Memory__Confusion__
Learning Disabilities____
Poor Comprehension____
Poor Phys. Coordination___
Difficulity wt Decisions____

LUNGS
Chest Congestion____
Asthma, Bronchitis____
Difficulty breathing____

DIGESTIVE TRACT
Diarrhea____
Constipation____
Bloated feeling___
Heartburn____
Intestinal/Stomach pain___

EMOTIONS
Mood Swings____
Anxiety, fear, nervous___
Anger, irritability____
Agressiveness____
Depression___

JOINTS/ MUSCLE
Pain/ Aches in Joints____
Arthritis____
Stiffness____
Limitation of movement____
Pain/ Aches in Muscles____
Weakness or Tired____

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BREAST HEATLTH
Fibroystic_____
Other _____

WEIGHT
Binge eating____
Binge drinking____
Food Cravings____
Excessive Weight____
Water Retention____
Underweight_____

OTHER
Frequent Illness____
Frequent Urination____
Genital itch____
Genital Discharge____

PATIENT MEDICAL HISTORY:

CARDIOVASCULAR
High blood pressure___
Angina____
Arythmia____
Heart Attack____
Bypass____
Angioplasty____
Congestive Heart Failure
Pulmonary Edema____

GASTROINTESTINAL
Ulcer____
Irrable Bowel____
Colitis____
Gallstones____
Hemorrhoid____
Hemptitis____
Liver Disease____

PULMONARY
Asthma____
Pneumonia____
Emphysemia____
C.O.P.D.____
Lung Embolus____
Chronic Bronchitis____

ENDOCRINE
Diabetes____
Hypoglycemia____
Hypothyroid____
Hyperthyroid____

UROLOGIC
Kidney Stones____
Blood in Urine____
Cystitis____
Prostatitis____
Renal(kidney) failure___
Sexually trans disease__

NEUROLOGIC
Seizure____
Multiple Sclerosis____
ADD/ADHD___
T.I.A.____
Other____

MUSCULOSKETAL
Arthritis____
Rheumatoid Arth____
Gout____
Bursitit____
Spine____
Disc disease____

FEMALES
PMS____
Menopausal Syndrom____
Irregular Menstrual Cycle__
Infertility____

MEDICATION ALLERGIES:_____

MEDICATION PRESENTLY TAKING:_____

HOSPITALIZATION & SURGERIES:_____

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