Greenwich Health, PLLC
Julie Huang-Lionnet, MD
1472 Post Road, Darien, CT 06820
P: 203.900-3996 or 203.900.3995

Board Certified Anesthesiology
Subspecialty Certification in Interventional Pain Management
Certified in Venous, Regenerative and Cosmetic Medicine
F: 203.900.3998 or 203.902-0166 ▪ www.greenwichhealth.org

PATIENT COMPREHENSIVE QUESTIONAIRE

INTERVENTIONAL PAIN / REGENERATIVE / SPORTS MEDICINE

REFERRAL PROVIDER INFORMATION Date of Request: _______/_______/_______

Requesting Provider: ____ NPI#: ______________________________

Phone #: (_________) __________________________ Fax #: (_________) __________________________________

Primary Care Physician (*if different*): ____ NPI#: ______________________________

Phone #: (_________) __________________________ Fax #: (_________) __________________________________

PATIENT INFORMATION

Patient Last Name: ________________________ First Name: ________________________ Middle Name: ____________________________

Gender: ☐ Male ☐ Female DOB: _______/_______/_______ Age: ___________

Home Address: ____
City State Zip Code

Home Phone #: (_________) __________________________ Cell/Message Phone: (_________) __________________________________

INSURANCE-PRIMARY

Name of Insurance: ____________________________ ID#: _________________________________ Group: ______________________

Insured's Name: ______________________________________ Insured's Date of Birth: ______/______/______ Relationship: _____________

Insured's Social Security #: ______-____-______ Insurance Phone #: (_________)________________

Employer's Name: _____________________________ Employer Address: ____
City State Zip Code

INSURANCE-SECONDARY

Name of Insurance: ____________________________ ID#: _________________________________ Group: ______________________

Insured's Name: ______________________________________ Insured's Date of Birth: ______/______/______ Relationship: _____________

Insured's Social Security #: ______-____-______ Insurance Phone #: (_________)________________

Employer's Name: _____________________________ Employer Address: ____
City State Zip Code

WORKER'S COMPENSATION OR MOTOR VEHICLE / AUTO

Employer Name: ____ Date of Injury: ________________ ID or Claim#: __________________

Insurance Company: _____________________________________ Insurance Company Phone #: (__________) ________________

Claim Address: ____
City State Zip Code

Adjuster's Name: ____ Phone #: (____________)________________________

Attorney's Name: ____ Phone #: (____________)________________________

Other Notes/Information: ____

WELCOME!
GREENWICH HEALTH IS COMMITTED TO PARTNERING WITH YOU TO MAKE A DIFFERENCE.

We believe that the more you know about GREENWICH HEALTH, PLLC, the better we can partner with you to make a difference. So, please take a few minutes to read and become familiar with the following:

1. **OFFICE HOURS:**

Clinical Office	Tuesday (Darien, CT)	9:00 AM-5:00 PM
	Wednesday (New York, NY)	8:00 AM-3:00 PM
Administrative	Monday-Friday	9:00 AM-5:00 PM

2. **TELEPHONE CALLS:**
GREENWICH HEALTH, PLLC's Physician and clinical staff attempt to be thorough and complete during your visit, including answers to all of your questions. You will notice that the clinical staff will rarely be interrupted by the telephone during your visit (unless another doctor is calling.) This is because we ask our patients to respect one another's time by holding their questions until their scheduled visit. We encourage you to write down all of your questions so you will not forget.

In other words, GREENWICH HEALTH, PLLC's Physician, nurse or medical assistants do not accept phone calls except in very unusual circumstances. If you have a clinical question that you believe can NOT wait until your regularly scheduled visit, you may call the office at (203)900-3996. Please, follow the prompts. Your question will be assessed and triaged according to the clinical significance then responded to accordingly. Please do **NOT** leave duplicate messages.

3. **CANCELLATIONS:**
Cancellations not made within 24 hours will be subject to a fee per payment and cancellation policy. Please contact our office to cancel or re-schedule with at least 24 hours' notice.

4. **PRESCRIPTIONS:**
All prescriptions must be picked up in person at a scheduled office visit, not on procedure appointment. For medications that can be called in, allow 4 working days to receive your prescription. Please call in your prescription request at (203) 900-3996.

Patients who come in for pain management frequently must take medicines for a variety of ailments such as high blood pressure, diabetes, heart disease, etc. **You will need to fill these prescriptions through your Primary Care Provider.**

5. **INSURANCE:**
As a courtesy, GREENWICH HEALTH, PLLC will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards.
   - Many procedures that are performed by GREENWICH HEALTH, PLLC require preauthorization from your insurance carrier. It is not uncommon for authorization to require up to 10-14 days.
   - Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan.
   - If any changes in your insurance coverage or benefits occur while being treated at GREENWICH HEALTH, PLLC, you are responsible to notify us immediately.

6. **FINANCIAL POLICY:**
I understand that if I am not **ELIGIBLE** under the terms of my medical and hospital subscriber health insurance agreement, I am **LIABLE for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the Practice.

7. **CO PAY'S/DEDUCTIBLES:**
If your insurance coverage requires co-pay, it will be collected when you check in, before you see the physician provider. Deductibles are determined by your Insurance Company, GREENWICH HEALTH, PLLC will notify you of your responsibility after explanation of benefits are received.

8. **FORMS:**
GREENWICH HEALTH, PLLC requires that all types of forms be completed **during a scheduled office visit**. If you need a form filled out by the physician, please notify the scheduler of this fact. Fees are as follows:
1st page $30.00 Each additional page $15.00

9. **OFFICE VISIT PRINTED RECORD**: Same day office visit medical record will be available upon request, please ask physician

10. **REFERRAL POLICY:**
GREENWICH HEALTH, PLLC is a specialty-based practice. Patients are scheduled upon referral only.

11. **PRIMARY CARE PHYSICIAN:**
If you are referred to GREENWICH HEALTH, PLLC by another specialist, it is imperative that you have a relationship with a **primary care physician**. Our physician serves as consultants and cannot assume the role provided by a primary care doctor.

12. **EMERGENCIES:**
Fortunately, there are very few medical emergencies related to chronic pain. However, if you believe you are experiencing such an emergency, you should go immediately to the nearest urgent care facility or emergency room. The physician attending to your problem in the urgent care facility or emergency room should be the one to call and communicate with your pain care provider. You should request that physician to do so. Therefore, it is only in very unusual circumstances that an unscheduled or urgent visit is necessary.

Patient Printed Name: ______________________________ Patient Signature: ______________________________

Date: ______________________

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Patient Name: ___________________________________ **Date of Birth:** _______/_______/_______ **Date:** _______/_______/_______

Please tell us the problem you would like us to help you with, including symptoms and attach pertinent medical records, imaging, test results, and physician visits, including specialists (CC): Side: ☐Right ☐Left

____

____

The onset of your pain was:

☐Motor Vehicle Accident
Date of Accident:______________
Seatbelt: ☐Yes ☐No
Position during the accident:
☐Driver ☐Passenger: Front / Back

☐Injury at work:__________________
☐Other Injury:____________________
Date of Injury:______________
☐Trauma:_______________________

☐Playing a Sport:__________________
☐Lifting / Twisting / Bending
☐Post-Surgery:____________________
Other Disease:_____________________

☐Falling from a height / Slipping ☐Legal Action Pending ☐Cancer_:______________________

Which words **BEST** describe your pain, please check all that apply

____	THROBBING	____	ACHING	____	SHARP	____	DULL	____	IN A GLOVE DISTRIBUTION
____	BURNING-HOT	____	NUMBNESS	____	STABBING	____	ELECTRIC	____	IN A STOCKING DISTRIBUTION
____	PINS & NEEDLES	____	SHOOTING	____	CRAMPING	____	TENDER	____	OTHER:
____	HEAVY	____	SPLITTING	____	GNAWING	____	TIRING		

Timing of your Symptoms:

☐ Constant ☐ Worse during or after activity ☐ Worse in the morning

☐ Intermittent / On / Off ☐ Worse during or at end of the day ☐ Worse during the night

☐ Other:____________________________ ☐ Worse during cold seasons ☐ Better when:______________________

Your pain has been occurring for:_____________________ ☐ Days ☐ Weeks ☐ Months ☐ Years

Please rate your pain on the following scale **ZERO** is **NO PAIN**, while **10** is the **WORST IMAGINABLE**

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

NO PAIN **WORST PAIN**

How Severe is your Pain: ☐**MILD** ☐**MODERATE** ☐**SEVERE** ☐**INTOLERABLE**

IN THE BOXES BELOW PLEASE TELL US IF YOUR PAIN LIMITS THE FOLLOWING ACTIVITIES

Please Indicate if makes Pain Better (B), Worse (W), or No Effect (NE)			
____	Heat	____	Walking / Long Distances
____	Sitting	____	Massage/Rubbing
____	Fatigue	____	Alcoholic Beverages
____	Coughing	____	Noise
____	Vibration	____	Lying Down / Laying Flat
____	Climate	____	Particular Position or Movement
____	Cold	____	Lifting Objects
____	Standing	____	Bending Forward
____	Anxiety/Emotions	____	Caffeinated Drinks
____	Rotating the Neck	____	Standing for Long Periods of Time

Onset of Pain was:	____	Sudden
	____	Gradual
My Pain is:	____	Improving
	____	Worsening
	____	Unchanged
Pain Frequency:	____	Continuously
	____	Several Times/ Day
	____	Once-Twice/ Day
	____	Several Times/ Week
	____	Less than 3-4x/ Month

Initial:_______

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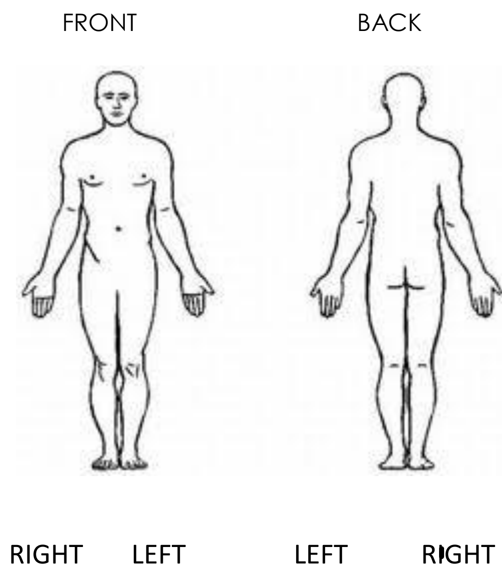
SHADE IN OR CIRCLE WHERE YOU EXPERIENCE PAIN

FRONT BACK



RIGHT LEFT LEFT RIGHT

Have you had any	*YES*	*NO*	*cervical*	*thoracic*	*lumbar*	*Details (explain)*
MRI'S	☐	☐	☐	☐	☐	Results: ____________
X-Rays	☐	☐	☐	☐	☐	Results: ____________
CT Scan	☐	☐	☐	☐	☐	Results: ____________
CT Myelogram	☐	☐	☐	☐	☐	Results: ____________

PLEASE INDICATE IF YOU HAVE TRIED ANY OF THESE TREATMENTS AND IF THEY WERE EFFECTIVE

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF	DETAILS
Activity Modification	☐	☐	☐	____________
Brace	☐	☐	☐	____________
What Type of Brace?	☐ Back Brace ☐ Neck Brace ☐ Cervical Traction ☐ TENS Unit ☐ Ankle Brace (R or L) ☐ Wrist Brace (R or L) ☐ Knee Brace (R or L)			
How Long have you Tried?	____________			
Are you Obtaining Relief?	____________			
Are your Products in Good Condition?	____________			
Surgery	☐	☐	☐	____________
Physical Therapy/Exercise Program	☐	☐	☐	____________
Chiropractor / Manipulation	☐	☐	☐	____________
Acupuncture	☐	☐	☐	____________
Massage / Relaxation Therapy	☐	☐	☐	____________
Biofeedback / Hypnosis / Counseling	☐	☐	☐	____________
Pilates / Yoga	☐	☐	☐	____________
Weight Reduction	☐	☐	☐	____________
Injections/Nerve Blocks	☐	☐	☐	____________
Trigger Point Injection	☐	☐	☐	____________
Heat Treatment	☐	☐	☐	____________
Ice Treatment	☐	☐	☐	____________
Other (*Explain*):	________	________	________	____________

*Initial:*_______

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PLEASE INDICATE ANY ASSOCIATIONS WITH YOUR PAIN:

Symptoms	Associated with your pain	Symptoms	Associated with your pain
Insomnia	☐	Awakens you from Sleep	☐
Change in Bladder Function	*(If YES, Explain)* ______	Sexual Dysfunction	*(If YES, Explain)* ______
Changes in Bowel Function	*(If YES, Explain)* ______	Appetite Changes	*(If YES, Explain)* ______
Changes in Temperature in the Affected Area	☐	Sweating in Affected Areas	☐
Leg Numbness	☐	Flushing in Affected Area	☐
Finger Numbness	☐	Toe Numbness	☐
Arm Numbness	☐	Hand Numbness	☐

**Is pain causing depression or anxiety? YES/NO *(If YES, Explain)* ______	**Do you smoke tobacco? If NO, ☐ FORMER ☐ NEVER If YES, ☐ Since (date): ☐ Frequency:
How many hours do you sleep? ______	**Do you drink alcohol? If NO, ☐ FORMER ☐ NEVER If YES, ☐ Since (date): ☐ Frequency:
How many hours per day you work? ______	**Do you do any recreational drugs? YES/NO *(If YES, Explain)*______
How does the pain limit your activities? *(If YES, Explain)* Work/school?______ Household Chores?______ Social Interactions?______ Leisure?______ Sexual Activity?______	What is your current employment status? ______ Type of work? ______ Do you have pending a settlement of disability, workman's compensation, or a legal matter? YES/NO *(If YES, Explain)* ______

MARK ALL MEDICATIONS THAT HAVE BEEN TRIED FOR YOUR SYMPTOMS:

Opioids		**NSAIDS/Tylenol/Analgesics**		**Muscle Relaxants**
☐ Tramadol	☐ Methadone	☐ Tylenol (Acetaminophen)	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Tramadol
☐ Hydrocodone (Vicodin)	☐ Butorphanol (Stadol)	☐ Indocin	☐ Acetaminoph/ aspirin/caffeine	☐ Zanaflex
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene	☐ Butalbital/ aspirin/caffeine	☐ Robaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Skelaxin
		☐ Butalbital/ acetam/caffeine		☐ Valium (Diazepam)

Anti-Depressants		**Other (Neuropathic Pain)/Anticonvulsants/Ergot Derivatives/Triptans**		
☐ Elavil (Amitriptyline)	☐ Paxil (Paroxetine)	☐ Neurontin (Gabapentin)	☐ Lyrica	☐ Almotriptan
☐ Pamelor (Nortriptyline)	☐ Prozac (Fluoxetine)	☐ Tegretol	☐ Ativan	☐ Eletriptan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax	☐ Frovatriptan
☐ Imipramine (Tofranil)	☐ Cymbalta (Duloxetine)	☐ Topamax (Topiramate)	☐ Imitrex	☐ Naratriptan
☐ Zoloft (Sertraline)	☐ Savella (Milnacipran)	☐ Depakote (Divalproex sodium)	☐ Ergotamine	☐ Rizatriptan
☐ Celexa (Citalopram)				☐ Sumatriptan

☐ Doxepin ☐ Mirtazaprine ☐ Effexor (Venlafaxine)	☐ Depakote ☐ Fluvoxamine ☐ Protriptyline	☐ Klonipin ☐ Mexilitine ☐ Ergotamine/caffeine	☐ Dihydroergotamine (DHE) ☐ Valproate (Valproic Acid)	☐ Zolmitriptan ☐ Sumatriptan/ naproxen

Do you have any adverse effects since starting any treatment?

☐ Constipation ☐ Drowsiness ☐ Mental Slowness ☐ Other:____________________________

Interventional Pain and Procedure History

Who have you seen for this problem?

PROCEDURE	Mark ALL if Applicable	EVALUATED BY:	Mark ALL if Applicable
No Procedure	☐	Primary Care	☐
Epidural Steroid Injection	☐ Lumbar ☐ Thoracic ☐ Cervical	Orthopedic Surgery	☐
Facet Joint Injection	☐ Lumbar ☐ Thoracic ☐ Cervical	General Surgery	☐
Medial Branch Block Injection	☐ Lumbar ☐ Thoracic ☐ Cervical	Neurosurgery	☐
Radiofrequency Ablation	☐ Lumbar ☐ Thoracic ☐ Cervical	Emergency Room	☐
Trigger Point Injections	☐ Lumbar ☐ Thoracic ☐ Cervical	Pediatrics	☐
Peripheral Nerve Injection	☐	Chiropractor	☐
Intrathecal Pump	☐	Physical Therapy	☐
Spinal Cord Stimulator	☐	Neurology	☐
Fusion, combined anterior and posterior, anterior, or posterior	☐	Therapist	☐
Laminectomy	☐	Exercise Trainer	☐
Micro-discectomy	☐	Urgent Care	☐
Other: __________		Other: __________	

Past Medical History (Please Check All that Apply)
****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

☐ Anemia, Chronic	☐ PFO (patent foramen ovale)	☐ Headaches	☐ Obesity
☐ Anxiety	☐ Depression	☐ Migraines	☐ PBPH
☐ Asthma	☐ Diabetes, Insulin Dependent	☐ Hyperthyroidism	☐ Pelvic Congestion Syndrome
☐ Atrial Fibrillation	☐ Diabetes, Non-Insulin Dependent	☐ Hypothyroidism	☐ Prostate Cancer
☐ Arm Pain	☐ End Stage Renal Disease	☐ Joint Pain	☐ Pregnancy
☐ Arthritis	☐ Emphysema	☐ Kidney Stones	☐ Peripheral Neuropathy
☐ Breast Cancer	☐ COPD – on O2?	☐ Low Back Pain	☐ Radiculopathy
☐ Bronchitis	☐ GERD	☐ Leg Pain	☐ Radiation Therapy
☐ Broken Bones	☐ Hepatitis	☐ Fibromyalgia	☐ Seizures
☐ Easy Bruising	☐ High Blood Pressure/Hypertension	☐ Joint Pain	☐ Stroke
☐ Chronic Pain	☐ HIV/AIDS	☐ Muscle Disease	☐ Ulcer (GI)
☐ Colon Cancer	☐ High Cholesterol	☐ Leukemia	☐ Shingles
☐ Coronary Artery Disease: Angioplasty / Stents?	☐ Heart Failure	☐ Lung Cancer	☐ Peripheral Arterial Disease
	☐ Pacemaker	☐ Lymphoma	☐ Leg Trauma / Surgery
	☐ Heart Attack	☐ Migraine	☐ Blood Clot – DVT / PE
Anti-coagulation?	☐ Irregular Heart Beat	☐ Multiple Myeloma	☐ Ulcer (Wound)
☐ Murmurs	☐ Hyperparathyroidism	☐ Memory Loss	☐ Other: __________

How has the pain limited you? (Check mark all that apply)

ACTIVITIES	LIMIT PAIN	ACTIVITIES	LIMIT PAIN
No Limitations	☐	Inability to Attend School	☐
Attending School on a Limited Basis	☐	Inability to Perform Daily Activities (ADL's)	☐
Difficulty Getting up from Chair	☐	Inability to Work	☐

Difficulty Sitting	☐	Requiring Constant Assistance	☐
Difficulty Standing	☐	Requiring Occasional Assistance	☐
Difficulty Walking	☐	Working on a Limited Basis	☐
Difficulty with Daily Activities (ADL's)	☐	Working Light Duty	☐
Difficulty with recreational sports	☐	Other:______________________________	☐
Functional Limitations	☐	______________________________	☐

Musculoskeletal History (Please Check All that Apply)
****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

☐ Ankle Fracture	☐ Osteoarthritis	☐ Soft Tissue Sarcoma
☐ Ankylosing Spondylitis	☐ Osteopenia	☐ Spinal Stenosis, Cervical
☐ Bursitis	☐ Osteoporosis	☐ Spinal Stenosis, Thoracic
☐ DISH	☐ Primary Bone Sarcoma	☐ Spinal Stenosis, Lumbar
☐ Epidural Injections, Spine	☐ Psoriatic Arthritis	☐ Vertebral Body Compression Fracture
☐ Fracture	☐ Rheumatoid Arthritis	☐ Vitamin D Deficiency
☐ Gout	☐ Ricketts	☐ Wrist Fracture
☐ Hip Fracture	☐ Complex Regional Pain Syndrome	☐ Rotator Cuff Tear
☐ Herniated Disc, Cervical	☐ Neuropathic Pain	☐ Tendonitis
☐ Herniated Disc, Lumbar	☐ Sciatica	☐ Plantar Fasciitis
☐ Herniated Disc, Thoracic	☐ Scoliosis	☐ Ligament Hypertrophy
☐ Metastatic Bone Disease	☐ Spine Fracture	☐ Other: ______________________________

Musculoskeletal Surgery (Please Check All that Apply)

☐ Achilles Tendon Repair
☐ ACL Reconstruction
☐ Ankle Fracture ORIF
  ☐ Right ☐ Left ☐ Both
☐ Carpal Tunnel Decompression
  ☐ Right ☐ Left ☐ Both
☐ Cervical Spine Surgery: ACDF
☐ Cervical Spine Surgery: Posterior Approach
☐ Cervical Spine Surgery: Disc Replacement
☐ CMC Arthroplasty
☐ Distal Radius ORIF
  ☐ Right ☐ Left ☐ Both
☐ Bunion Correction
☐ Ganglion Cyst Excision
☐ Intramedullary Nailing Femur
  ☐ Right ☐ Left ☐ Both
☐ Intramedullary Nailing Tibia
  ☐ Right ☐ Left ☐ Both
☐ Joint Replacement: Knee
  ☐ Right ☐ Left ☐ Both
☐ Joint Replacement: Shoulder
  ☐ Right ☐ Left ☐ Both
☐ Joint Replacement: Hip
  ☐ Right ☐ Left ☐ Both

☐ Knee Arthroplasty
  ☐ Right ☐ Left ☐ Both
☐ Knee Arthroscopy
  ☐ Right ☐ Left ☐ Both
☐ Kyphoplasty
☐ Vertebroplasty
☐ Lumbar Fusion
☐ Lumbar Laminectomy
☐ Lumbar Spine Surgery: Decompression
☐ Lumbar Spine Surgery: Decompression and Fusion
☐ Lumbar Spine Surgery: Disc Replacement
☐ Meniscus Repair
☐ Rotator Cuff Repair
  ☐ Right ☐ Left ☐ Both
☐ Reverse Total Shoulder Replacement
☐ Revision of Total Hip Arthroplasty
☐ Revision of Total Knee Arthroplasty
☐ Revision of Total Shoulder Arthroplasty
☐ Shoulder Arthroscopy
☐ None
☐ Other;: ______________________________
____

PAST SURGICAL HISTORY
****PLEASE LIST ALL SURGERIES, INCLUDE ALL SPINE SURGERIES****

*Initial:*_______

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Surgery	Date

ALLERGIES (Please list all allergies or check options, which applies):

□ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
□ No Known Drug Allergies (NKDA)

Allergy Type	Please Describe Allergic Reaction Severity and Symptoms

MEDICATIONS (Please list all current medications or check options, which applies):

- Complete the information below regarding all medications currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medications, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications.

	BLOOD THINNERS		
☐	Aggrenox/Dipyridamole	☐	Heparin/LMWH
☐	ASA 325mg	☐	Lovenox/Enoxaparin
☐	Brilinta/Tricagrelor	☐	Plavix/Clopidogrel
☐	Cilostazol/Pletal	☐	Pradaxa/Dabigatran
☐	Coumadin/Warfarin	☐	Savaysa/Edoxaban
☐	Effient/Prasugel	☐	Trental/Pentoxifylline
☐	Eliquis/Apixaban	☐	Ticlid/Ticlopidine
☐	Fragmin/Dalteparum	☐	Xarelto/Rivaroxaban
☐	Gingko/Garlic/Vitamin E		

Name of Drug, and Supplements	Strength or Dosage	Number of tablets	Total number of tablets per day	Reason for taking medication

____	____	____	____	____
____	____	____	____	____

PHARMACY NAME	ADDRESS	PHONE & FAX
____	____	____

SOCIAL HISTORY (Please check all that apply):

Smoking	Alcohol Use	Drug Use	Exercise Frequency
☐ Never Smoked	☐ Do no drink alcohol	☐ No History of Drug Use	☐ Never
☐ Quit: Former Smoker	☐ Less than 1 drink a day	☐ Positive History of Drug Use	☐ Once a Day
☐ Smokes Less than Daily	☐ 1-2 drinks a day	☐ IV Drug Use	☐ Few Times a Week
☐ Smokes Daily:	☐ Social Drinker – occasionally per week		☐ Few Times a Month
# Packs/Day____		☐ If Yes for Option 2 or 3, please detail drugs used:____	☐ Several Times a Day
☐ Other: ____	☐ 3 or more drinks a day	____	☐ Other: ____

SOCIAL HISTORY **FAMILY HISTORY**

	MARITAL STATUS		LIVING STATUS		CHILDREN		FRATERNAL		MATERNAL
____	Married	____	Lives alone	____	YES	____	Alcohol	____	Alcohol
____	Single	____	Lives w/spouse	____	NO	____	Drug Use	____	Drug Use
____	Divorced	____	Lives w/family	____	How many?				
____	Widow	____	Other	____	Boy				
				____	Girl				

FAMILY HISTORY (Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, PLEASE mark the box under the relationship of the person to you.

CONDITION	PLEASE MARK YES OR NO			RELATIONSHIP OF PERSON TO YOU				
	YES	NO	Unknown	Father	Mother	Grandparent	Brother/Sister	Son/Daughter
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke / TIA	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Depression/ Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐	☐	☐	☐
Venous Insufficiency	☐	☐	☐	☐	☐	☐	☐	☐
Other Conditions: ____	☐	☐	☐	☐	☐	☐	☐	☐

OTHER MEDICAL CONDITIONS* (Check Yes or No for the following)
*Please inform the physician, medical assistant, or front desk staff of any other medical conditions or concerns.

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Blood Thinners	☐	☐	Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐	Diabetes	☐	☐
Defibrillator	☐	☐	Hepatitis B or C	☐	☐

Premedication Prior to Procedure	☐	☐	HIV / AIDS	☐	☐
Other Biomedical Implant or Hardware	☐	☐	Leg Ulceration	☐	☐
Any Type of Blood Clots	☐	☐	PFO (Patent Foramen Ovale)	☐	☐
Clotting Disorder (or Family History)	☐	☐	Migraines with Aura	☐	☐
Superficial Thrombophlebitis / Vein Disease	☐	☐	Migraines without Aura	☐	☐

REVIEW OF SYSTEMS (Check Yes or No if you are currently experiencing any of the following)

CONSTITUTIONAL		**YES**	**NO**		**YES**	**NO**
	Fever	☐	☐	Chills	☐	☐
	Weight Loss	☐	☐	Environmental Allergies	☐	☐
	Weight Gain	☐	☐	Dizziness	☐	☐
	Fatigue	☐	☐	Fainting	☐	☐
EYES	Blurred Vision	☐	☐	Double Vision	☐	☐
	Eye Pain	☐	☐	Glaucoma	☐	☐
EARS/NOSE/MOUTH	Hearing Aids?	☐	☐	Loss of Hearing	☐	☐
	Ringing in the Ears	☐	☐	Hoarseness	☐	☐
	Nose Bleeds	☐	☐	Excessive Thirst	☐	☐
CARDIOVASCULAR	Chest Pain	☐	☐	Ankle or Leg Swelling	☐	☐
	Shortness of Breath	☐	☐	Labored Breathing with Exertion	☐	☐
	Palpitations	☐	☐	Pedal Edema	☐	☐
RESPIRATORY	Cough	☐	☐	Pain with Breathing	☐	☐
	Wheezing	☐	☐	Rib Pain	☐	☐
GASTROINTESTINAL	Reflux	☐	☐	Difficulty Swallowing	☐	☐
	Stool - Incontinence	☐	☐	Nausea	☐	☐
	Diarrhea	☐	☐	Vomiting	☐	☐
	Constipation	☐	☐	Heartburn	☐	☐
	Ulcers	☐	☐	Blood in Stool	☐	☐
GENITOURINARY	Urinary Tract Infection	☐	☐	Urinary Retention	☐	☐
	Urinary Hesitancy	☐	☐	Blood in Urine	☐	☐
	Urinary Incontinence	☐	☐	Genital Pain	☐	☐
MUSCULOSKELETAL	Muscle Pain	☐	☐	Joint Swelling	☐	☐
	Joint Pain	☐	☐	Joint Stiffness	☐	☐
INTEGUEMENTARY	Skin Rash	☐	☐	Scarring	☐	☐
	Discoloration	☐	☐	Edema	☐	☐
NEUROLOGICAL	Syncope	☐	☐	Incontinence	☐	☐
	Dizziness	☐	☐	Headaches	☐	☐
	Difficulty Walking	☐	☐	Tremor	☐	☐
	Weakness	☐	☐	Seizure	☐	☐
	Numbness	☐	☐	Memory Loss	☐	☐
	Tingling	☐	☐	Frequent Falls	☐	☐
PSYCHIATRIC	Depression	☐	☐	Anxiety	☐	☐
	Suicidal Thoughts	☐	☐	Hallucinations	☐	☐
ENDOCRINE	Diabetes	☐	☐	Heat Intolerance	☐	☐
	Thyroid Disease	☐	☐	Cold Intolerance	☐	☐
HEMATOLOGY/LYMPHATIC	Bleeding tendencies	☐	☐	Excessive Bleeding	☐	☐
	Immunosuppression	☐	☐	Excessive Bruising	☐	☐
CANCER	______________________	☐	☐	______________________________	☐	☐

*Initial:*_______

Greenwich Health, PLLC
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Certified in Venous, Regenerative and Cosmetic Medicine
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Smoking Cessation: Smoking Dangers (tobacco use):
Smoking and second hand smoke are harmful to your health. If you smoke, STOP! If you are around others who smoke, encourage them to stop. Smoking leads to chronic obstructive pulmonary disease, and increases risk of heart disease, cancer, and stroke. There are many medications and aids available to help you stop smoking. For additional help and/or information, call 1-800-NO-BUTTS (1-800-662-8887) or 1-800-LUNG-USA (1-800-586-4872). (99406)

STAFF REVIEW:

Comments	URINE TOX-6	URINE TOX-12	P	N
	COC	THC	☐	☐
	OP	COC	☐	☐
	AMP	OPI	☐	☐
	MET	AMP	☐	☐
	BZO	MET	☐	☐
	OXY	PCP	☐	☐
	BY:	MDM	☐	☐
		BAR	☐	☐
		BZO	☐	☐
		MTD	☐	☐
		TCA	☐	☐
		OXY	☐	☐
		BY:		

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