Philip R. Corvo, MD, MA, FACS
133 Scovill St Suite 308
Waterbury, CT 06706
(203) 709-5900 P (203) 709-5910 F

HISTORY & PHYSICAL

NAME: ____ **MALE □** **FEMALE □**
OTHER NAMES USED:____
ADDRESS:____
PHONE #_______________________________ **DOB**________________ **AGE**______
ALTERNATE #____________________________ **SS#**__________________________
PRIMARY PHYSICIAN_____________________________ **PHONE**______________
REFERRING PHYSICAN___________________________ **PHONE** _____________
PHARMACY______________________**LOCATION**____________**PHONE**_________

What is the nature of your problem?____
____

List of current medical problems and doctors/specialists

Medical Problem **Doctor** **Medical Problem** **Doctor**

1.____________________________________ 5.__________________________________
2_____________________________________ 6.__________________________________
3.____________________________________ 7.__________________________________
4.____________________________________ 8.__________________________________

Please list all of your prior surgeries

Operation **Date** **Surgeon/Hospital** **Complications**

1.____
2.____
3.____
4.____
5.____

Have you been hospitalized for any reason other than the above listed surgeries?

1.____
2.____
3.____

What medications do you take? (Include prescription, over the counter, vitamins, natural supplements)

1.______________________________________ 6.___________________________________
2______________________________________ 7.___________________________________
3.______________________________________ 8.___________________________________
4.______________________________________ 9.___________________________________
5.______________________________________ 10.__________________________________

Have you used Aspirin/ibuprofen/blood thinner in the past week? ☐ Yes ☐ No

Do you have drug allergies?

Name	Reaction	Name	Reaction
1.______________________________________		3.___________________________________	
2______________________________________		4.___________________________________	

Is there any family history of heart disease, hypertension, diabetes, bleeding disorders or problems with anesthesia?

1.____
2.____
3.____
4.____

Any family history of **Breast cancer?** Who:___________________________
Ovarian cancer? Who:___________________________
Uterine cancer? Who:___________________________
Colon cancer? Who:___________________________
Prostate cancer? Who:___________________________
Pancreatic cancer? Who:___________________________
Melanoma? Who:___________________________
Other cancers? Who:___________________________

Do you have Jewish Ancestry? ☐ Yes ☐ No
Occupation________________________________ Are you married?___________________
Number of Children?_________ Number of Pregnancies_____ Did you breast feed?____
Date of 1st menstrual period___________ Age of last menstrual period_____________
Did you ever use oral contraceptives?__________ For how long?____________
Have you ever taken hormones?________________ For how long?____________

Do you smoke?_________ How much?________ Did you quit? How long ago?________
Dou you drink?_________ How much?_________
Do you use IV drugs?___________ Did you ever?_______ When did you stop? _______
Do you drink caffeinated beverages?__________ How Much?_______
Last PAP______________________ Doctor______________________
Last Colonoscopy________________ Doctor______________________
Last Mammogram________________ Doctor______________________
Is there anything else you would like us to know?________________________________

REVIEW OF SYSTEMS

Please check any of the following problems which apply to you. If none apply, please check "none"

GENERAL

□ Weight Loss □ Weight gain □ Fevers □ Night Swears
□ Decreased energy □ Decreased strength □ None

HEENT

□ Change of vision □ Blurry vision □ Floaters □ Double Vision
□ Blind spot □ Ear pain □ Ringing ears □ Nose bleeds
□ Sinus Problems □ Bleeding gums □ Dental difficulties □ Hoarseness
□ Neck stiffness □ Neck tenderness □ Neck masses □ None

CARDIOVASCULAR

□ Chest pains □ Palpitations □ High Blood Pressure □ Leg swelling
□ Lightheadedness □ Heart murmurs □ Varicose veins □ Blue toes
□ Calf pain when walking □ Shortness of breath while sleeping

RESPIRATORY

□ Pain in chest □ Wheezing □ Cough □ Sputum
□ Bloody sputum □ Emphysema □ Tuberculosis □ Shortness of breath
□ Asthma □ Pneumonia □ Infections

GASTROINTESTINAL

□ Change in appetite □ Nausea □ Vomiting □ Heartburn
□ Reflux □ Ulcers □ Food intolerance □ Hernia
□ Abdominal Pain □ Hemorrhoids □ Bloody stool □ Jaundice
□ Diarrhea □ Constipation □ Abnormal stools □ Excessive gas
□ Change in bowel habits

GENITOURINARY

□ Incontinence □ Urgency □ Frequency □ Blood in urine
□ Change in urine color □ Bladder infection □ Change in stream □Kidney Stones
□ Pain on urination □ Sexual dysfunction □ Change in libido □ Heavy periods
□ Painful periods □ Painful intercourse □ Vaginal discharge □ Genital sores
□ Sexually transmitted disease □ Post-menopausal bleeding

MUSCULOSKELETAL

□ Bone pain □ Joint pain □ Arthritis □ Motion limitation
□ Muscle weakness □ Muscle cramps □ None

SKIN

□ Rash □ Itching □ Infections □ Nail changes □ Change in mole

BREAST

□ Lumps □ Pain □ Change in shape □ Nipple discharge
□ Change in skin □ Tenderness □ None

NEUROLOGIC
□ Headache □ Dizziness □ Convulsions □ Seizures
□ Weakness □ Paralysis □ Tremor □ Memory problems
□ Poor coordination □ Problems with sensation □ None

PSYCHIATRY
□ Depression □ Emotional problems □ Anxiety □ Hallucinations
□ Previous psychiatry care □ None

ENDOCRINE
□ Diabetes □ Thyroid problems □ None

BLOOD/LYMPHATIC
□ Anemia □ Clotting problems □ Easy bruising □ HIV
□ Bleeding problems □ Difficulty stopping bleeding □ Prior transfusions
□ Enlarged lymph nodes □ Rh incompatibility □None

For office use only

Reviewed: ______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______

New Medications:

Date:	Medications and Dose

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_______ _______ _______ _______ _______ _______ _______ _______
_______ _______ _______ _______ _______ _______ _______ _______
_______ _______ _______ _______ _______ _______ _______ _______
_______ _______ _______ _______ _______ _______ _______ _______
_______ _______ _______ _______ _______ _______ _______ _______

New Medications:

Date:	Medications and Dose

PLEASE FILL OUT ALL SECTIONS OF THIS FORM. ACCURACY IS VITAL FOR PROPER INSURANCE SUBMISSION.

Name: ____ Today's Date: __________________

First Middle Last

Home Address: ____

City: _________________________________ State: _________ Zip: ______________

Telephone: ( ) __________________ Birthdate: ________________ Age: _______

Email Address: _________________________________ (for use of patient portal only)

Marital Status: __Single __Married __Divorced __Widowed

Occupation: ___________________________________ SSN: _________________________

Employment status: __Employed __Unemployment __Retired

Employer: ____ Years There: ____________

Employer's Address: ____

City: _________________________________ State: _________ Zip: ______________

Work Phone: ( ) ______________________________

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: __________________________________ Relationship to Patient: ________

Home Address: ____

City: _________________________________ State: ___________ Zip: _____________

Telephone: ( ) ____________________ Birthdate: __________________ Age:_______

Occupation: ____ SSN:______________________

Employer: ____ Years There: ____________

Employer's Address: ____

City: _________________________________ State: _________ Zip: ____________

Work Phone: ( ) ______________________________

In case of emergency, contact: ______________________________ Relationship: __________

Home Phone: (   ) ________________________   Work Phone: (   ) ____________________

May we give Medical information to a spouse or other party if you are not available? If so, please give us a name.

____Date:__________________________

How did you learn about our practice? ____

Insurance Information

Patient's Name:____ Today's Date:__________
First   Middle   Last

[Primary Insurance]
Name of Insurance Company:
____
Address: ____
City: ________________________________   State: _________   Zip: ______________
Insured's Name: ____
Group Number: ________________________   Policy ID Number: ____________________

[Secondary Insurance]
Name of Insurance Company:
____
Address: ____
City: ________________________________   State: _________   Zip: ______________
Insured's Name: ____
Group Number: ________________________   Policy ID Number: ____________________

Signed: ____________________________   Date: ____________________
(Patient or responsible party)