

# Gastroenterology Associates of Fairfield County



(203) 292-9000  
425 Post Road  
Fairfield, CT 06824  
Referring MD  
Chart Number:

(203) 333-3328  
2660 Main Street  
Bridgeport, CT 06606

Date: \_\_\_\_\_

Date:

Marital status S M W D

Patient Name:

Age:

DOB:

Gender:

## Patient History Form

Please complete the following information:

List any prescription medication, herbal remedies, vitamins and over-the-counter medications you take:

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medication? Yes No (*please circle one*) if yes, please list. \_\_\_\_\_

\_\_\_\_\_

Have you ever had a flexible sigmoidoscopy or colonoscopy in the past? Yes No (*please circle one*) If yes, when?

\_\_\_\_\_

List all surgeries: \_\_\_\_\_

\_\_\_\_\_

List medical conditions for which you are under the care of a healthcare provider:

\_\_\_\_\_

\_\_\_\_\_

Family History: (*Please circle any that apply to a blood relative*)

Diabetes    High Blood Pressure    Heart Disease    Colon Cancer    Colon Polyps    Ulcer Disease

Other: \_\_\_\_\_

Review of Symptoms: (*Please circle any symptoms you are experiencing at the present time*)

Lack of energy	Heartburn	Pain with urination	Chronic cough
trouble sleeping	Difficulty swallowing	Blood in urine	Sleep apnea
Weight loss	Regurgitation	Pregnant	Painful menses
Weight gain	Sour taste in mouth	Joint swelling	New skin rash
Fever	Changes in vision	Joint redness	Depression
Excessive thirst	Palpitations	Joint pain	Anxiety
Constipation	Post nasal drip	Back pain	Numbness/Tingling
Diarrhea	Sore throat	Muscle aches	
Nausea	Voice change	Chest pain	
Vomiting	Wheezing	Swollen legs	
Rectal bleeding	Hormonal problems	Shortness of Breath	
Abdominal pain	Frequent urination	Coughing up blood	

Date of last menstrual period \_\_\_\_\_

Occupation \_\_\_\_\_

Do you smoke/former smoker? Yes/No How much per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Drink alcohol/former drinker? Yes/No    Quantity per week \_\_\_\_\_

Drink caffeinated beverages? Yes/No    Quantity per week \_\_\_\_\_

Use IV drugs or nasal cocaine? Yes/No    When? \_\_\_\_\_

**How did you hear about our practice?** \_\_\_\_\_

MD/APRN initials: \_\_\_\_\_ Date: \_\_\_\_\_ MD/APRN initials: \_\_\_\_\_ Date: \_\_\_\_\_