Connecticut Gastroenterology Associates, PC.

Patient Information

Name: _____Date of Birth _____Date_____

Please complete the following:

List allergies to medication: _____

List any prescription medication you take: _____

_____

List any herbal medicine/over the counter medicines/vitamins: _____

_____

List all surgeries and dates: _____

_____

List medical problems for which you are under care of a healthcare provider: _____

_____

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 day _____
….use IV drugs or nasal cocaine? Yes __ No __ when? _____

Please indicate if you are experiencing any of the following at the present time:

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

_____MD/PA