CONNECTICUT GASTROENTEROLOGY ASSOCIATES, P.C.

NAME: _____ D.O.B. _____ DATE: _____

Chief Complaint: _____

Pharmacy: _____ Primary Care Doctor: _____

Have you had a colonoscopy before?: _____ If yes, When?: _____

Check (X) all boxes that apply to you				Medications	
				Rx Name	Dosage
Lack of energy		History of asthma			
Feeling tired		Frequent Urination			
Recent Change in weight		Blood in urine			
Fever		History of dyspepsia			
Stool consistency looser		Back pain			
Stool consistency harder		Joint swelling			
Change in stool frequency		Joint pain			
Vomiting blood		Muscle achs			
Heartburn		Breast lump			
Difficulty swallowing		Skin rash			
Food sticking in chest		Paralysis			
Pain on swallowing		Seizure		Surgical Procedures	Medical Problems
Yellow skin or eyes		Memory loss			
Chest pain or discomfort		Depression			
Pounding heartbeat		Anxiety			
Palpitation		Diabetes			
Limb swelling		Excessive thirst			
Fainting		Bleeding excessively			
Shortness of breath		Easy bruising			
Wheezing		Allergy to shellfish			
Coughing up blood		Reaction to contrast dye			

Please list any allergies: _____

Family History		Check (X) boxes that apply to you	
Disease/Illness	Family Member (P-paternal/ M-maternal)		
		Never a smoker	Stopped drinking alcohol
		Former smoker	*when? _____
		Current smoker	Former cocaine use
		Uses Alcohol	Former IV drug use
		*how much per week	On Methadone/suboxone program