(203) 292-9000
425 Post Road
Fairfield, CT 06824

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

Date:_____

Patient Name:

Patient History Form

Please complete the following information:

DOB: Age:

Gender: M F Marital status: S M W D

Referring MD: Chart Number:

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 Systems: *(Please circle any symptoms you are experiencing at the present time)*

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

Date of last menstrual period _____

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:_____