Connecticut Gastroenterology Consultants, P.C.
(203) 777-0304
40 Temple Street, Suite 4A
New Haven, CT 06510

REF *

Age:
Gender:
Provider:

Patient Medical History

Date:

NAME: _____ DATE OF BIRTH: _____
LAST FIRST M.I.

PHONE: (H) _____ (W) _____ (Cell) _____

REASON FOR VISIT: _____

PREVIOUS OR CURRENT MEDICAL PROBLEMS: (example: High blood pressure, Diabetes)

_____

_____

_____

_____

PREVIOUS SURGERIES AND HOSPITALIZATIONS (example: Appendectomy) DATES:

_____

_____

_____

_____

ALLERGIES:

_____

LIST MEDICATIONS: (include dose, number of pills per day, etc.)

_____ _____ ☐ ASPIRIN
_____ _____ ☐ ADVIL, Etc.
_____ _____ ☐ ANTACID
_____ _____ ☐ LAXATIVES
_____ _____ ☐ VITAMINS
_____ _____ ☐ HERBAL MEDS

FAMILY HISTORY:

Colon Cancer	☐ yes	☐ no	Crohn's Disease or Ulcerative Colitis	☐ yes	☐ no
Stomach Cancer	☐ yes	☐ no	Colon Polyps	☐ yes	☐ no
Pancreatic Cancer	☐ yes	☐ no	Liver Disease	☐ yes	☐ no
Peptic Ulcer Disease	☐ yes	☐ no	Gallstones	☐ yes	☐ no

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union

OCCUPATION: _____ ☐ Retired

HABITS:

Do you Smoke?	☐ yes	☐ no	If yes, how much per day? _____
Do you drink alcohol?	☐ yes	☐ no	If yes, how much per day? _____
Have you had a blood transfusion?	☐ yes	☐ no	
Have you used illegal drugs?	☐ yes	☐ no	

RECENT LAB WORK:
when: _____
where: _____

RECENT X-RAY (within the past year):
what: _____
where: _____
when: _____

Patient Medical History

Date:

REF *

Patient Name:
DOB:
Age:
Gender:
Provider:

REVIEW OF SYSTEMS

GENERAL (constitutional/endocrine/heme/psych)
- ☐ chronic fatigue
- ☐ weight loss (amount _____ since when? _____)
- ☐ fever
- ☐ other
- ☐ NO COMPLAINTS

EARS, EYES, NOSE, & THROAT
- ☐ ringing in ears
- ☐ ear infections
- ☐ dizzy spells
- ☐ poor vision
- ☐ glaucoma
- ☐ sinus troubles
- ☐ hoarseness
- ☐ eye infections
- ☐ cataracts
- ☐ other
- ☐ NO COMPLAINTS

LUNGS
- ☐ pneumonia
- ☐ asthma
- ☐ shortness of breath
- ☐ bronchitis
- ☐ cough
- ☐ other
- ☐ NO COMPLAINTS

HEART
- ☐ chest pain
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ Do you take antibiotics prior to dental procedure.
- ☐ palpitations
- ☐ ankle swelling
- ☐ phlebitis (blood clots)
- ☐ murmur
- ☐ other
- ☐ NO COMPLAINTS

SKIN (skin/allergic, immunology)
- ☐ rashes
- ☐ allergic reactions
- ☐ hives
- ☐ other
- ☐ NO COMPLAINTS

GASTROINTESTINAL
- ☐ diarrhea
- ☐ heartburn
- ☐ nausea
- ☐ blood in the stool
- ☐ liver disease
- ☐ trouble swallowing
- ☐ constipation
- ☐ stomach cramps
- ☐ vomiting
- ☐ bloating
- ☐ gas
- ☐ other
- ☐ NO COMPLAINTS

URINARY
- ☐ urine infections
- ☐ kidney stones
- ☐ decrease in urine force or flow
- ☐ blood in urine
- ☐ painful urination
- ☐ urination at night (more than twice)
- ☐ other
- ☐ NO COMPLAINTS

BONES & JOINTS
- ☐ arthritis/rheumatism
- ☐ back pain (chronic/recurrent)
- ☐ gout
- ☐ osteoporosis
- ☐ other
- ☐ NO COMPLAINTS

NEUROLOGIC/PSYCHIATRIC
- ☐ stroke
- ☐ tremor/hands shaking
- ☐ numbness or tingling
- ☐ headaches (frequent)
- ☐ memory loss
- ☐ depression
- ☐ panic attacks
- ☐ migraines
- ☐ seizures
- ☐ anxiety
- ☐ other
- ☐ NO COMPLAINTS

HEMATOLOGIC / LYMPHATIC / ONC
- ☐ anemia
- ☐ cancer
- ☐ bruises easily
- ☐ other
- ☐ NO COMPLAINTS

ENDOCRINE
- ☐ heat intolerance
- ☐ excessive thirst
- ☐ thyroid disease
- ☐ cold intolerance
- ☐ diabetes
- ☐ other
- ☐ NO COMPLAINTS

☐ **ALL OTHER REVIEW OF SYSTEMS NEGATIVE**

DATE REVIEWED/UPDATED:

_____ _____

Date

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REF *

Patient Name:
DOB:
Age:
Gender:
Provider:

Patient Registration

Date:

PATIENT NAME: _____ SSN: _____
LAST FIRST MI

STREET ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

MARITAL STATUS:	**RACE:**	**ETHNICITY:**	**LANGUAGE:**
☐ Single	☐ American Indian	☐ Hispanic Origin	☐ English
☐ Married	☐ Asian	☐ Non-Hispanic Origin	☐ Spanish
☐ Widowed	☐ Black or African American		☐ Other _____
☐ Divorced	☐ Native Hawaiian		
☐ Civil Union	☐ White		

EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ OCCUPATION: _____

CITY: _____ STATE: _____ ZIP: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

PHARMACY NAME _____ ADDRESS _____ PHONE _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

SPOUSE/PARTNER INFORMATION

NAME: _____ DOB: _____ SSN: _____

SPOUSAL EMPLOYER: _____ SPOUSAL EMPLOYER PHONE: _____

INSURANCE INFORMATION

PRIMARY INS. CO: _____ ID#: _____ GROUP#: _____

SECONDARY INS. CO.: _____ ID#: _____ GROUP#: _____

FINANCIAL POLICY: I authorize payment of medical benefits directly to CONNECTICUT GASTROENTEROLOGY CONSULTANTS for services furnished to me by that physician/supplier. I authorize release of information to process claims for services furnished me by CONNECTICUT GASTROENTEROLOGY CONSULTANTS, P.C.

HIPAA COMPLIANCE: I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

MEDICARE ASSIGNMENT: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

PATIENT Rx CONSENT: I agree that Connecticut Gastroenterology Consultants, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

SIGNATURE: _____ **DATE:** _____
Patient, Parent or Guardian if minor