PACT Physicians Alliance of Connecticut | Hartford HealthCare

PACT Gastroenterology Center

Hamden • Milford • Guilford

Welcome back to the PACT Gastroenterology Center!

Welcome back to our practice and thank you for choosing us for your medical care. To continue providing you with high quality service, we ask that you complete the enclosed **Patient History Form** and return it to us in the envelope provided. Please also note, if your insurance company requires a formal referral from your primary care physician, you must verify that the referral is in place prior to your appointment or your appointment will be rescheduled.

On the day of your appointment, please make sure you have your insurance card and driver's license with you. When you check-in, we will copy both and collect the co-pay required by your insurance plan (if applicable). For your convenience, we accept cash, check, MasterCard and Visa.

If you have any questions before your appointment, please contact us at (203) 281-4463.

For additional information about our practice or gastroenterology in general, please visit our website at www.gastrocenter.org

We look forward to seeing you again on,

Appt. Date	
Time	
Provider Name	
Office	

Tel: 203-281-4463 www.pactmd.com Fax: 203-287-2930

2200 Whitney Avenue Suites 330 & 360 Hamden CT 06518 | 40 Commerce Park Milford CT 06460 | 1591 Boston Post Road Suite 206 Guilford CT 06437

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Questions? Contact us at (203) 281-4463

Section 1:

Name:_____ DOB:_____

Preferred Contact Phone Number:_____ Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Insurance Information:_____ ID#_____

Referral Information:

- Who referred you:_____Reason for referral:_____

Pharmacy:_____ Interpreter needed? ☐Yes ☐No Language:_____

Section 2:

Who is your medical proxy or conservator?_____

Can we leave messages at number listed in Section 1? ☐Yes ☐No

Can we leave messages with people other than yourself? ☐Yes ☐No

- If yes, who:_____

Do you have an advance directive or medical power of attorney? ☐Yes ☐No

- If yes, name and number:_____

Do you live in a nursing home or assisted living? ☐Yes ☐No

Do you see any specialist(s): ☐None ☐Cardiologist ☐Pulmonologist ☐Kidney Specialist ☐Gynecologist ☐Other:_____

Section 3:

Do you use any medical equipment? ☐None ☐Hearing aids ☐Other:_____

Do you wear: ☐Dentures ☐Glasses ☐None

Do you have any oral or facial piercings? ☐Yes ☐No If yes, are they removable? ☐Yes ☐No

Any trouble with anesthesia or breathing tube? ☐Yes ☐No Any hospitalizations in the last 30 days? ☐Yes ☐No

Oxygen use? ☐Yes ☐No Pacemaker? ☐Yes ☐No AICD? ☐Yes ☐No History of angioedema? ☐Yes ☐No

Do you have any communicable disease? ☐None ☐C-Diff ☐MRSA ☐VRE ☐TB

History of substance abuse? ☐Yes ☐No

Section 4 (Allergies):

Are you allergic to any medication? ☐Yes ☐No

Drug:_____ Reaction:_____
Drug:_____ Reaction:_____
Drug:_____ Reaction:_____
Drug:_____ Reaction:_____

Metal Allergies: ☐None ☐Nickel ☐Other:_____
Food Allergies: ☐None ☐Eggs ☐Nuts ☐Soy ☐Sulfites ☐Other:_____
Are you allergic to contrast dye? ☐Yes ☐No

Medical History

Any past gastrointestinal medical history? ☐Yes ☐No

Gastrointestinal/Liver:
☐None
☐Celiac Disease
☐Reflux disease or Barrett's Esophagus
☐H-pylori infection, ulcer disease
☐C-Diff Colitis
☐Inflammatory Bowel Disease (Crohn's disease/Colitis)
☐Gallbladder Disease
☐Hepatitis
☐Fatty Liver

Cardiovascular Disease:
☐None
☐Hypertension
☐High Cholesterol
☐Chest pain/Angina
☐Heart Attack/Coronary Artery Disease
☐Heart Valve Issues
☐Abnormal EKG
☐Heart rhythm Issues
☐Atrial Fibrillation
☐Pacemaker/Defibrillator
☐Angioplasty
☐Stents-What type?_____
☐Heart Surgery

Neurology:
☐None
☐Stroke or TIA
☐Seizures If yes, last episode?_____
☐Parkinson's disease
☐Multiple Sclerosis
☐Fainting episodes
☐Weakness or Numbness

Endocrine:
☐Diabetes ☐Insulin pump
☐Thyroid disease

Pulmonary:
☐None
☐Chronic Cough
☐Asthma
☐COPD/Oxygen use
☐History of Tuberculosis
☐Sleep apnea/CPAP use
☐Pneumonia/Bronchitis

Renal/Rheumatologic Disease:
☐None
☐Rheumatoid Arthritis
☐Fibromyalgia
☐Spine disorders
☐Neck mobility issue
☐Osteoporosis
☐Lupus
☐Chronic kidney disease
☐Kidney failure/dialysis

Hematology/Oncology:
☐Bleeding disorders
☐Anemia If yes, what type_____
☐Clotting disorders
☐Pulmonary Embolism
☐Sickle Cell disease
☐Cancer History

Women's Health:
☐Excessive menstrual bleeding
☐Endometriosis
☐ Polycystic Ovarian Syndrome
☐History of episiotomy/tear during childbirth
☐Incontinence
☐Frequent UTIs
☐Pregnant

Past Surgical History

☐ None
☐ Angioplasty/Stent
☐ Pacemaker/Defibrillator
☐ Heart valve surgery If yes, type_____ Need antibiotic coverage? ☐ Yes ☐ No
☐ Hernia repair
☐ Abdominal surgery – If yes, ☐ Appendectomy ☐ Gallbladder ☐ Intestinal surgery
☐ Joint replacement – Need antibiotic coverage? ☐ Yes ☐ No
☐ Spine surgery
☐ Breast surgery
☐ Hysterectomy
☐ C-Section

Social History

☐ Alcohol Use – If yes, type_____ Frequency_____

☐ Smoking – If yes, frequency_____

☐ Vaping – If yes, frequency_____

☐ Marijuana Use – If yes, frequency_____

☐ IV Drug Use – If yes, frequency_____

Family History

☐ Colon Cancer – Who:_____ Age:_____
☐ Colon Polyps – Who:_____ Age:_____
☐ Uterine Cancer
☐ Family Cancer Syndromes
☐ Pancreatic Cancer
☐ Crohn's disease or Colitis
☐ Celiac Disease
☐ Liver Disease
☐ Hemochromatosis

Medications

Over the counter medications? ☐Yes ☐No If yes, please list:_____

Vitamins? ☐Yes ☐No If yes, please list:_____

Herbal Supplements? ☐Yes ☐No If yes, please list:_____

List of prescribed medications:

Do you take any anticoagulants or blood thinners? ☐Yes ☐No
If yes, prescribing doctor:_____

Medication_____ Dosage_____ Frequency_____
Medication_____ Dosage_____ Frequency_____
Medication_____ Dosage_____ Frequency_____
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