CTHerniaCenter • CTColorectalCenter
Hamden • Branford • Ansonia

Patient Name: ______________________

Date of Birth: ______________

Past Medical History

Medications: Fill In Boxes: **(If you have medication list, Mail / hand-in with this form)*

Name of Medication	*Strength/How often*

Allergies to Medications:
**Name medication & Reaction you had:*
____
____
____
____
____

Pharmacy Name:____________________ **Pharmacy Address:**____________________**(Street name and Town)**

Past Medical History:
Please check box and specify if you have *ever* been diagnosed with any of the following:

☐Colon/Rectal	☐Hypertension (High Blood Pressure)
☐Cancer(Specify type)	☐Kidney Disease
☐Diabetes: ☐ Insulin or ☐ Non-Insulin	☐Lung Disease
☐Gastrointestinal (Stomach)	☐MRSA/MSSA
☐Heart Disease	☐Thyroid
☐Hernia	☐Other:

Past Surgical History: Have you *ever* had surgery? ☐ No, I have never had surgery.
☐ Yes. Please list surgeries below:

Type of Surgery	Date Performed	Type of Surgery	Date Performed

Turn over →

Social:

Alcohol Use: __Yes or __No **Type:** ☐Beer ☐Wine ☐Liquor ☐All Listed ☐Other__________
Frequency: ☐Daily ☐Weekly ☐Occasionally ☐Rarely ☐Socially

Caffeine Use: __Yes or __No

Type: ☐Coffee ☐Tea ☐Energy Drinks ☐Soda ☐Other:_________ **Amount Per Day**: ___________

Tobacco Use: __Yes or __No **Amount Per Day:**__________ **Number of Years Used:**_______

***If you answered *yes* to Tobacco Use, Please fill in the following box:**

Have you ever tried to quit? __Yes or __No
Which methods have you tried?____

Check the box of all that are true for you:

Triggers:

☐ Alcohol	☐Driving	☐Talking on the phone
☐Awakening	☐Meals	☐TV
☐Coffee	☐Stress	☐Other_____________

Check the box of all that are also true for you:

☐ I smoke in my home ☐ My coworkers smoke
☐ I smoke in my car ☐ I awake at night to smoke
☐ Has anyone close to you quit?

Family History: In the blank lines provided please list immediate family history

Mother ☐Alive ☐Passed Away	**Father** ☐Alive ☐Passed Away
☐Cancer (Type):______________________	☐Cancer (Type):______________________
Sister(s) ☐Alive ☐Passed Away	**Brother(s)** ☐Alive ☐Passed Away
☐Cancer (Type):______________________	☐Cancer (Type):___ ☐Cancer (Type):___
Grandmother(s) ☐Alive ☐Passed Away	**Grandfather(s)** ☐Alive ☐Passed Away
☐Cancer (Type):______________________	☐Cancer (Type):___ ☐Cancer (Type):___

☐No relevant family history
☐Adopted, no family history