

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

(such as Family Practice, Internal Medicine, Ob/Gyn)

City/State \_\_\_\_\_ / \_\_\_\_\_ City/State \_\_\_\_\_ / \_\_\_\_\_

**PLEASE READ COMPLETELY AND CAREFULLY**

Present Medical History: List the main complaints which lead to this office visit \_\_\_\_\_

Check **SIGNIFICANT** complaints below:

- Rectal bleeding:**     on toilet paper     bright red     black, tarry  
                                   into toilet bowl     dark red  
                                   with clots     mixed with stool     found on card test (not visible)

- Rectal pain:**     constant     increasing  
                                   with bowel movements     sporadic

- Rectal swelling**     hemorrhoids that come out     Rectal itching  
                                   Incontinence (soiling/accidents)

Other rectal concerns \_\_\_\_\_

- Abdominal pain     Nausea     Indigestion (frequent/severe)  
 Abdominal cramping     Vomiting     Stomach/Duodenal ulcer  
 Abdominal bloating     Vomiting blood     Esophageal reflux (hiatal hernia)

- Weight change** (past 6 months)     loss     gain ( \_\_\_\_\_ pounds)     Loss of appetite

Other Abdominal complaints \_\_\_\_\_

- Recent change in bowel habits    irregular bowel habits

- Diarrhea:**     loose     watery     mucous     bloody     How long? \_\_\_\_\_

- Constipation:**     infrequent stools     straining/difficulty     firm stools     How long? \_\_\_\_\_

Stools per day  1  2  3  4  5  6 or more or Stools per week  6  5  4  3  2  1  less than one

- Laxative use** (frequent)

- stool softeners (Surfax, Colace)     "natural" (herbal tea, senna, cascara)  
 stimulants (Ex-Lax, Dulcolax, Doxidan)     fiber (Metamucil, Citracel, Konsyl)     FiberCon

Other laxatives \_\_\_\_\_

How often used? \_\_\_\_\_ How long used? \_\_\_\_\_

- Current Diet:**  high fiber (more than 6 fruits/vegetables per day)  high fiber cereal (Fiber One, All Bran)

- other cereals     diabetic diet     avoid nuts, seeds, popcorn, etc.

- Coffee     Tea     Coca Cola     Carbonated beverages     Chocolate

**Water**  less than 4 glasses/day     4-8 glasses/day     more than 8 glasses/day

- DRUG ALLERGIES:**     No Known Drug Allergies

- penicillin     sulfa     local anesthesia (Novocain/Lidocaine)     codeine

- Allergy to IV dye (Iodine)     "mycins"

Other drug allergies \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

**Family History**

<b>Mother</b>	<input type="checkbox"/> living	age _____	<input type="checkbox"/> deceased	Cause _____
<b>Father</b>	<input type="checkbox"/> living	age _____	<input type="checkbox"/> deceased	Cause _____
<b># brothers</b>	living _____	deceased _____		Cause _____
<b># sisters</b>	living _____	deceased _____		Cause _____

**adopted**

**Has any relative had:**

<input type="checkbox"/> <b>Colon polyps:</b>	<input type="checkbox"/> parent	<input type="checkbox"/> brother/sister	<input type="checkbox"/> child	<input type="checkbox"/> grandparent/aunt/uncle/cousin
<input type="checkbox"/> <b>Colon Cancer:</b>	<input type="checkbox"/> parent	<input type="checkbox"/> brother/sister	<input type="checkbox"/> child	<input type="checkbox"/> grandparent/aunt/uncle/cousin
<input type="checkbox"/> <b>Ulcerative colitis:</b>	<input type="checkbox"/> parent	<input type="checkbox"/> brother/sister	<input type="checkbox"/> child	<input type="checkbox"/> grandparent/aunt/uncle/cousin
<input type="checkbox"/> <b>Crohn's disease:</b>	<input type="checkbox"/> parent	<input type="checkbox"/> brother/sister	<input type="checkbox"/> child	<input type="checkbox"/> grandparent/aunt/uncle/cousin

**Other conditions within your family:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung cancer	<input type="checkbox"/> bleeding disorders	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart attack	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> stroke	<input type="checkbox"/> dementia <input type="checkbox"/> seizure
<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> Breast cancer	<input type="checkbox"/> lymphoma	<input type="checkbox"/> leukemia <input type="checkbox"/> TB

Other family diseases \_\_\_\_\_

**Past Medical History**

**Have you had prior diagnosis of:**

<input type="checkbox"/> colon polyps	<input type="checkbox"/> colon cancer	<input type="checkbox"/> diverticulitis
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> spastic colon (irritable bowel)
<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> anal fissure/ulcer	<input type="checkbox"/> rectal abscess

**Previous surgery:**  Hemorrhoidectomy  Anal fissure/ulcer  Drain rectal abscess

Colon resection  Appendectomy  Gallbladder  Exploratory

stomach surgery ( resection for cancer/ulcers  bypass)  bowel obstruction

Hysterectomy (remaining ovaries:  none  one  both)  tubal ligation  C-section

Breast ( cancer  benign  implants  reduction)  Prostate ( benign  cancer)

Open heart  heart valve  angioplasty  vascular bypass

Other \_\_\_\_\_

**List your current medications (Include blood thinners and aspirin, HERBAL/NATURAL)**

Medication/Dose	Times per day	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Social History**

smoking  chewing tobacco  snuff  alcohol use  drug abuse

single  married  separated  divorced  widow/widower

Occupation \_\_\_\_\_

retired

Name \_\_\_\_\_ Date \_\_\_\_\_

**Systems Review** (Other **SIGNIFICANT** concerns)

**General**

- good health       declining health       fever       fatigue

**Eyes**

Ophthalmologist \_\_\_\_\_

- glasses/contacts     glaucoma     cataracts     cataract surgery     blurred/double vision

**Ears, Nose, Mouth & Throat**

ENT Doctor \_\_\_\_\_

- hearing loss/ringing     hearing aid     chronic sinusitis     nose bleeds  
 earaches/drainage     mouth sores     bleeding gums     bad breath/taste  
 sore throat/voice change     swollen neck glands

**Heart & Vascular**

Cardiologist \_\_\_\_\_

- chest pain/angina     palpitations/heart racing     shortness of breath  
 wake up short of breath     ankle swelling     leg pain with walking     foot pain while sleeping

**Lungs**

Pulmonary Doctor \_\_\_\_\_

- chronic cough     coughing blood     difficulty breathing     asthma/wheezing

**Genitourinary**

Urologist \_\_\_\_\_ Ob/Gyn \_\_\_\_\_

- burning with urination     blood in urine     difficulty with urination     kidney stone  
 urinary incontinence     impotence     testicular pain     painful intercourse  
 normal periods     irregular period     post menopause  
Last menstrual period:  current    weeks ago  1  2  3  4 or more     possibly pregnant

**Musculoskeletal**

Orthopedist \_\_\_\_\_ Rheumatologist \_\_\_\_\_

- arthritis     muscular pain/weakness     back pain/disk disease     difficulty walking

**Skin/Breast**

Dermatologist \_\_\_\_\_

- psoriasis     chronic rash     change in hair/nails     varicose veins  
 breast lump     breast pain     nipple discharge

**Neurological**

Neurologist \_\_\_\_\_ Neurosurgeon \_\_\_\_\_

- chronic headaches     seizures     tremors     stroke     head injury

**Psychiatric**

Psychiatrist \_\_\_\_\_

- memory loss/confusion     anxiety     depression     insomnia

**Endocrine**

- Thyroid disease     Diabetes     Cushing's disease

**Hematologic/Lymphatic**

Oncologist \_\_\_\_\_

- Anemia     free bleeding     previous blood transfusions     AIDS

**Allergy**

Allergist \_\_\_\_\_

- food allergy     environmental allergy (hay fever, dogs/cats, pollen etc.)

**Other** \_\_\_\_\_

Thank you