

Name _____ Age _____ DOB _____

Referring MD _____ Primary MD _____

Reason for Visit: (chief complaint) _____

Medical Conditions: (ex. diabetes) _____

Prior Surgeries: (procedure and year) _____

Medications: (list drugs including aspirin, add sheet if needed) 4) _____ mg _____ times/day

1) _____ mg _____ times/day 5) _____ mg _____ times/day

2) _____ mg _____ times/day 6) _____ mg _____ times/day

3) _____ mg _____ times/day 7) _____ mg _____ times/day

Medication Allergies: _____

Family History: What diseases run in your family? Colon/Rectal Cancer Polyps Colitis/Crohn's Dz other

Explain: _____

Social History: Marital status: Single Married Occupation: _____ Tobacco _____ packs/day Alcohol _____ drinks or beers/day Recreational drugs type(s) _____

Colon and Rectal Symptoms and History: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Anal or rectal pain | <input type="checkbox"/> Anal discharge | <input type="checkbox"/> Difficulty evacuating stool |
| <input type="checkbox"/> Anal protrusion | <input type="checkbox"/> Blood on toilet paper | <input type="checkbox"/> Strain/push to evacuate stool |
| <input type="checkbox"/> Push protrusion back inside | <input type="checkbox"/> Blood in toilet | <input type="checkbox"/> Use fingers to push out stool |
| <input type="checkbox"/> Anal swelling | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Rectal fullness |
| <input type="checkbox"/> Anal itching | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fecal Incontinence/soilage |
| <input type="checkbox"/> Anal burning | <input type="checkbox"/> Change in stool size/frequency | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Anal tags | <input type="checkbox"/> Change in stool consistency | <input type="checkbox"/> Abdominal cramping |
| <input type="checkbox"/> Difficulty cleansing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Abdominal bloating |

Do you have a history of:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Fissure/tear | <input type="checkbox"/> Anal/Genital Warts | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Abscess | <input type="checkbox"/> Anal Cancer | <input type="checkbox"/> Colon/Rectal Polyps |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Colon/Rectal Cancer | <input type="checkbox"/> Diverticular Disease |
| <input type="checkbox"/> Fistula | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Irritable Bowel Syndrome |

How often do you move your bowels? _____ times/day _____ times/week

The usual consistency of your stool is: Hard Formed Mixed Liquid AlternatesDo you regularly use: Laxatives (brand) _____ Enemas Fiber Stool softeners

Do you use anal creams/suppositories/medicated or wet wipes? (list) _____

Have you previously had a: Colonoscopy Flexible Sigmoidoscopy Barium Enema

Last Colonoscopy: (year) _____ By Doctor: _____ Results: _____

Review of Systems: (check all that apply)**Constitutional:**

- weight loss
- fever
- chills
- sweats
- fatigue
- poor appetite
- weakness

Cardiovascular:

- heart attack
- chest pain/angina
- stent placement
- irregular beat
- atrial fibrillation
- valve disease
- mitral prolapse
- valve replacement
- use antibiotics for dentist
- rapid beat
- pacemaker
- high blood pressure
- leg swelling
- aneurysm
- poor circulation
- high cholesterol

Blood:

- blood clots
- on Coumadin/Warfarin
- on Plavix
- aspirin daily
- sickle cell
- leukemia/lymphoma
- easily bruise/bleed
- hemophilia
- sickle cell disease

Pulmonary:

- asthma
- emphysema/COPD
- shortness of breath
- cough
- embolism
- lung mass/nodule
- tuberculosis

Endocrine:

- diabetes
- hypothyroid/low
- hyperthyroid/high
- steroid use

Gastrointestinal:

- ulcers
- vomit blood
- heartburn
- reflux
- nausea
- vomiting
- liver cirrhosis
- jaundice
- hepatitis
- ascities
- hernia

Genitourinary:

- painful urination
- blood in urine
- air in urine
- urinary infections
- kidney stones
- renal failure/dialysis
- sexually-transmitted dz
- genital warts
- incontinence

Male:

- testicle lump
- erectile dysfunction
- prostate enlargement
- prostatitis
- prostate cancer
 - radiation therapy

Female:

- breast mass/cancer
- pain with intercourse
- vaginal discharge
- hysterectomy
- cystocele
- vaginal fistula
- endometriosis
- abnormal Pap smear
- currently pregnant
 - how far along? ____ weeks
- # children _____
- vaginal delivery(s) # _____
- episiotomy/tear # _____
- forceps # _____
- C-section(s) # _____
- breast feeding currently
- menopause

Psychiatric:

- anxiety
- depression
- alcohol dependence
- postpartum depression

Eyes:

- wear glasses
- cataracts
- glaucoma
- blindness

Ears/Nose/Throat:

- nose bleeds
- oral bleeds
- hoarseness
- deafness
- ear ringing

Skin:

- rash
- psoriasis
- itching
- warts
- skin cancer
- shingles

Musk/Skeletal:

- arthritis
- joint pain
- back pain
- disc disease
- gout

Neurological:

- stroke
- TIAs
- nerve damage
- seizures
- dizziness
- memory loss

Immune:

- transplanted organ
- fibromyalgias
- lupus
- rheumatoid arthritis
- HIV/AIDS

other:

Patient's Signature _____ Date _____

History reviewed with patient Doctor's Signature _____ Date _____