Patient Medical Questionnaire-Colon and Rectal Clinic LLC

Patient Name: _____Age: _____ Date of Visit: _____ Gender: Male/Female (Circle)

Height: _____ Weight: _____ Referred by: _____ Primary Care Physician: _____

Other Physicians: _____

Chief Complaints: _____

Previous Illnesses: ❑Heart Disease ❑High Blood Pressure ❑Stroke ❑Heart Attack _____year ❑High Cholesterol ❑Angina or Chest Pain ❑ Heart Surgery ❑Implanted Defibrillator or pace maker ❑Lung Disease ❑Asthma ❑Diabetes Type I or II ❑Low Thyroid ❑Cancer ____if so what kind_____ ❑Ulcerative Colitis ❑Crohns Disease ❑Irritable Bowel Syndrome ❑Colon Polyps

Medications: (Please list all medications that you are currently taking and their doses)

_____

_____

❑Aspirin, ❑Plavix, ❑Coumadin, ❑Other Blood Thinners, ❑Pradaxa, ❑Ticlid

Allergies: (Please list any medication you are allergic to and explain the reaction to the medication)

_____/No Known Drug Allergies (Circle)/ Latex allergy

Review of Systems: (Please check the box, if you do not check, we assume no)

General: ❑Chills, ❑Fatigue, ❑Night Sweats, ❑Weight Loss

Skin: ❑New Lesions and ❑Rash

HEENT: ❑Blurred Vision and ❑Decreased Hearing

Respiratory: ❑Bloody Sputum, ❑Cough, ❑Difficulty Breathing, ❑Wheezing

Cardiovascular: ❑Chest Pain, ❑Difficulty breathing on Exertion and ❑Palpitations

Genitourinary: ❑Painful Urination, ❑Frequency, ❑Blood in Urine ❑Urgency

Musculoskeletal: ❑Joint Pain, ❑Joint Stiffness and ❑Muscle Weakness.

Neurological: ❑Seizures, ❑Black Outs, ❑Stroke

Psychiatric: ❑Anxiety and ❑ Depression

Endocrine: ❑Appetite Changes

Hematology: Anemia, ❑Blood Clots and ❑Excessive Bleeding

Past Surgical History (Please list all operations with the dates of occurrence): _____

_____

Obstetric: # of Pregnancies_____, # of Vaginal Deliveries_____, # of C sections_____, History of Episiotomy or Tear

Social History: Smoking ❑ Current every/some day smoker ❑Former smoker ❑Non- smoker

Alcohol ❑None ❑___Number of times a week ❑___Number of times of month ❑___Number of drinks each time

Diagnostic Studies:

❑Colonoscopy ❑Sigmoidoscopy ❑Barium Enema:

Dates_____, Finding_____, Physician_____

CT scan: Yes/No, If yes dates_____, Finding_____, Physician_____

Family History:

Colon Cancer or Rectal Cancer (Relationship to You/Age at Diagnosis):_____

Other Cancers (Relationship to You/Age at Diagnosis):

_____

Colon Polyps (Relationship to You/Age at Diagnosis):_____

❑Diabetes, ❑Cholesterol, ❑Heart Disease, ❑Lung Disease, ❑Others