

Colon and Rectal Clinic, P.A.

Patient Name: _____ Age: _____ Date of Visit: _____
Height: _____ Weight: _____

PREVIOUS ILLNESSES (Please list any illness you have had, and the dates of their occurrence)

PREVIOUS COLON SCREENING (Please list the most recent colon screenings you have undergone and the dates of their occurrence)

Flexible Sigmoidoscopy _____ Colonoscopy _____
 Barium Enema _____

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrence)

MEDICATION (Please list all medications that you are currently taking and their doses. Please include over-the-counter and herbal medications)

_____ Please note if you are on the following specifically:
Plavix Coumadin/warfarin Ticlid Aspirin

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

No Known Drug Allergies _____

FAMILY HISTORY (Please list your family member and the disease associated)

Colon Cancer _____ Other _____
 Rectal Cancer _____
 Polyps _____

REVIEW OF SYSTEMS (Do you currently have or had a history of the following? Please check all that apply. If you do not check the box, we assume that the answer is no.)

General

- Recurrent fever
- Significant weight change

Eye, Ear, & Throat

- Cataracts
- Glaucoma
- Retinopathy
- Sinus problems
- Dental problems
- Bleeding gums
- Hoarseness
- Recent sore throat
- Difficulty swallowing

Hematologic

- Anemia
- Blood disorder

Oncologic

- Chemotherapy
- Radiation

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Heart murmur
- Heart attack
- Abnormal heart valve

Abdominal/GI

- Swollen feet
- Abnormal stress test
- Pacemaker
- Blood thinner use
- High cholesterol
- Hernia
- Nausea/vomiting
- Reflux
- Peptic Ulcer
- Jaundice

Dermatologic

- Rash
- Skin cancer

Urologic

- Frequent urination
- Blood in the urine
- Urinary incontinence

Male Reproductive

- Prostate gland problems
- Abnormal PSA
- Difficulty urinating
- Penile discharge
- Testicular pain/mass

Endocrine

- Diabetes
- Thyroid problems
- Hormonal abnormalities
- Steroid use

Female Reproductive

- Irregular Menstruation
- Vaginal spotting
- Vaginal discharge
- Ovarian Cysts
- Endometriosis
- Number of previous pregnancies _____

Respiratory

- Sleep apnea
- Productive cough with sputum
- Shortness of breath
- Asthma
- Wheezing

Rheumatologic

- Back pain
- Joint pain
- Joint swelling
- Arthritis

Neurologic/Psychiatric

- Stroke
- Seizure
- Fainting or blackouts
- Anxiety
- Phobia
- Depression

Personal Habits

Do you smoke? _____
Do you drink alcohol? _____

Other

Primary Care Doctor

Other Physicians

I have reviewed the above information with the patient on this date. All boxes which are not checked are either negative or N/A.

Physician's Signature _____

Date _____