University Medical Group Department of Colon & Rectal Surgery

Patient Name:_____ **Date:**_____

SSN: _____ **Age:**_____

Reason for visit:_____

Referring Physician:_____

Primary Care Physician:_____

Pharmacy name, number, & address:_____

Please list MEDICATIONS and DOSAGE amounts that you are currently taking. Please write "None" if you have no medications.

_____

_____

_____

What medications are you allergic to? Please write "None" if no allergies.

Have you ever had any of the following medical problems? Please circle all that apply:

Anemia Anxiety Arthritis Asthma Back Pain Blood clots

Cancer (type)_____ HIV Heart Disease COPD Crohn's Disease

Diabetes DVT Dementia Fibromyalgia Hepatitis High Blood Pressure

Irritable Bowel Kidney Failure Kidney Stones Migraines Pacemaker

Parkinson's Disease Pilonidal Cyst Stroke

List any other medical problems:

Have you ever had any of the following surgical procedures? If so, circle all that apply:

Appendectomy Back surgery Colon surgery Breast surgery Heart Bypass

Heart Catheterization Gall bladder C section D&C Hemorrhoidectomy

Hernia Repair (groin, belly button, incisional, other) Hip replacement (left right)

Hysterectomy Knee Surgery (left right) Laparoscopy Tonsils

Prostatectomy TURP

Patient Name: _____ **DOB:**_____

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List any other surgical procedures you have had:

_____

_____

Do you have any of the following symptoms? Circle all that apply.

Trouble breathing		Anxiety	Abdominal pain/cramping		Back Pain
Bleeding problems/easy bruising			Blood in stool	Blood in urine	Chest pain
Chills	Confusion	Constipation	Depression	Diarrhea	Dizziness
Frequent urination		Heartburn/Reflux		Irregular Heartbeat	Painful urination
Rectal Pain	Seizures	Shortness of Breath		Leakage of Urine	Vomiting
Weakness	Weight Loss				

Do any of the following family members have any of the following diseases? Please circle all that apply.

Mother:	Colon/Rectal Cancer	Colon Polyps	Breast Cancer	Uterine Cancer	Colitis
Father:	Colon/Rectal Cancer	Colon Polyps			Colitis
Sister:	Colon/Rectal Cancer	Colon Polyps	Breast Cancer	Uterine Cancer	Colitis
Brother:	Colon/Rectal Cancer	Colon Polyps			Colitis
Child:	Colon/Rectal Cancer	Colon Polyps			Colitis

Social History

Do you smoke? Yes No If so, how much?_____

Do you drink alcohol Yes No If so, how much?_____