Colorectal Surgery History Form

SPECTRUM HEALTH
The Medical Group

Name____ Appointment Date____________________

DOB ____________________ Age _______ Gender □ Male □ Female Height_________ Weight________

Phone ____________________________ / ____________________________ / ________________________
(Circle Primary) Home Work Cell

I am a □New patient □Returning patient, previously seen by Dr.________________________(year)__________

Primary Care Physician___________________________ Referring Physician ___________________________

Pharmacy________________________________ (street/town)____

Reason for visit today ____

Are you **CURRENTLY** having any of the symptoms listed below?

CONSTITUTIONAL	YES	NO	CARDIOVASCULAR	YES	NO	MUSCULOSKELETAL	YES	NO
Activity Change If yes, □↑ □↓			Chest pain			Neck pain		
			Palpitations			Back pain		
Appetite Change If yes, □↑ □↓			Leg swelling			Joint pain		
			GASTROINTESTINAL (GI)			Muscle pain		
Fatigue			Trouble swallowing			Falls		
Fever			Heartburn			**NEUROLOGICAL**		
Weight change If yes, □↑ □↓ ___ lbs			Nausea			Speech difficulty		
			Vomiting			Seizures		
HENT			Abdominal Pain			Tremors		
Headaches			Constipation			Numbness/tingling		
Hearing loss			Diarrhea			Weakness		
Nosebleeds			Fecal incontinence			**PSYCHIATRIC**		
Congestion			Rectal pain			Depression		
Sore throat			Rectal bleeding			Anxiety		
EYES			**GENITOURINARY**			Sleep disturbance		
Eye discharge			Difficulty urinating			**SKIN**		
Eye pain			Painful urination			Itching		
Light sensitivity			Urine incontinence			Rash		
RESPIRATORY			Frequent urination			Wound		
Cough			Blood in urine					
Wheezing			Urinary urgency					
Shortness of breath			**ENDOCRINE/HEMATOLOGY**					
Snoring			Enlarged lymph nodes					
Sputum production			Bruises/bleeding					

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Patient Name: Birthdate:

Medical History/Illnesses *(please check all that apply)*

□ None □ Asthma □ Diabetes □ Heart Disease □ Irregular Heartbeat/Murmur □ Chest pain
□ COPD/Emphysema □ Heart Attack □ Hypertension □ Stroke □ Personal History of Cancer

Other Medical Illnesses____

Surgery	Date	Surgery	Date
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______

Have you ever had a colonoscopy? □Yes □No If yes, when? ____________________
Please list any findings from previous colonoscopies____________________
Which doctor did your last colonoscopy? ____________________
Have you had a CT/MRI of the abdomen or pelvis in the last 6 months? □ Yes □ No

Medications *(please include doses)*

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

I usually have _______ stools per □day □week □month
Are you on a fiber supplement? □Yes □No Have you ever been on a fiber supplement? □Yes □No

Allergies *(please list reactions)* □None
□Penicillin □Sulfa □Codeine □Demerol □Morphine □Iodine □Latex □Fish □Fentanyl □Versed
Other Allergies ____________________

Females
How many times have you been pregnant? ____________________
How many were vaginal delivery? ____________ C-Section?____________
Any obstetrical injuries (tears, lacerations, episiotomies) during delivery? □Yes □No ______________
When was your last menstrual period? ____________________

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Patient Name: **Birthdate:**

Social History

Current Occupation/Job ___________________________________ Full time or Part time? ____________

Do you currently smoke? □Yes □No Have you ever smoked? □Yes □No

How much do/did you smoke? ________________________________ How many years? ___________

Do you drink alcohol? □ Never □ Currently □ Past

How much do/did you drink? __________________ How often do/did you drink? ________________

How many caffeinated beverages do you drink per day? ______________________

Family History *(mark all that apply)*

Do you have any family members with ulcerative colitis? □Yes □No If yes, who? _______________

Do you have any family members with Crohn's disease? □Yes □No If yes, who? _______________

Do you have any family members with COLON/RECTAL cancer? □Yes □No *(if yes see box below)*

Do you have any family members with COLON/RECTAL polyps? □Yes □No *(if yes see box below)*

Relationship	*Circle One*	*Circle One*	*Circle One*	Age at Onset
____________________	Paternal/ Maternal	Colon or Rectal	Polyps or Cancer?	_________
____________________	Paternal/ Maternal	Colon or Rectal	Polyps or Cancer?	_________
____________________	Paternal/ Maternal	Colon or Rectal	Polyps or Cancer?	_________
____________________	Paternal/ Maternal	Colon or Rectal	Polyps or Cancer?	_________

Please list any other types of cancer in your family (other than colon/rectal) ________________________

____

Please indicate the health status of the following

Mother ____

Father ____

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Patient Name: **Birthdate:**

Quality of Life Related to Visit Problem

How has your visit problem impacted the following? Circle the appropriate answer.

Your ability to do household chores (cooking, housekeeping, laundry)?

Not at all	Somewhat	Moderately	Quite a bit

Your ability to do physical activities such as walking, swimming or other exercise?

Not at all	Somewhat	Moderately	Quite a bit

Entertainment activities such as going to a movie or concert?

Not at all	Somewhat	Moderately	Quite a bit

Your ability to travel by car or bus for a distance greater than 30 minutes away from home?

Not at all	Somewhat	Moderately	Quite a bit

Participating in social activities outside your home?

Not at all	Somewhat	Moderately	Quite a bit

Your emotional health (nervousness, depression, etc)?

Not at all	Somewhat	Moderately	Quite a bit

You feeling frustrated?

Not at all	Somewhat	Moderately	Quite a bit

Stool Accidents

For each question, please X the most appropriate box.

	NEVER	RARELY Less than once a month	SOMETIMES Less than once a week	USUALLY Less than once a day	ALWAYS Everyday
Solid stool leakage?					
Liquid stool leakage?					
Gas leakage?					
Pad use (for stool)?					
Lifestyle restriction?					