Date of Birth: ____________________________

Name:

Patient History Form

Please describe your reason for today s visit:____

What are you hoping to get out of today s visit?____

How long has this been going on?____

Does anything make your condition worse: No Yes Please describe____________________________

Does anything in particular help with your condition: No Yes Please describe____________________

Past Medical History **Please check any problem you have had or you are being treated for.**

Please check this box if NO current medical problems.

Blood Problems

- Anemia
- Blood clots (DVT/ Embolism)
- Bleeding disorder
- Clotting disorder
- HIV positive

Cardiac Vascular

- Angina (chest pain)
- Arrhythmia (heart rhythm problems)
- Atrial fibrillation
- Heart failure
- Hyperlipidemia: (high cholesterol)
- Hypertension: (high blood pressure)
- Malignant hyperthermia
- Past heart attack
- Peripheral vascular disease: (Blood vessel problems in legs)

Cancer

- Anal cancer
- Bladder cancer
- Breast Cancer
- Cervical cancer
- Colon cancer
- Kidney cancer
- Ovarian cancer
- Penile cancer
- Prostate cancer
- Rectal cancer
- Small bowel cancer
- Stomach cancer
- Urinary tract cancer
- Uterine (endometrial) cancer
- Vulva cancer
- Other Cancer: _______________

Eyes

- Glaucoma
- Vision loss

Endocrine

- Adrenal disease
- Diabetes
- Hyperthyroidism (high thyroid disease)
- Hypothyroidism low thyroid disease

Gastrointestinal

- Accidental bowel leakage
- Anal/Rectal trauma/injury
- Celiac disease (gluten sensitivity)
- Colon/Rectal polyps
- Crohn s disease
- IBS (Irritable bowel syndrome)
- Ulcerative colitis

Infection

- Hepatitis
- MRSA
- VRE

Kidney/Urinary

- Poor kidney function
- Renal failure
- Urinary incontinence (leakage of urine)

Mental Health

- Anxiety
- Depression

Musculoskeletal

- Arthritis
- Back problems
- Gout
- Pelvic fracture

Neurological

- Multiple sclerosis
- Neuropathy
- Seizures
- Spinal cord injury
  - Cervical
  - Thoracic
  - Lumbar
  - Sacral
  - Unknown
- Stroke (Cerebrovascular accident)
- Brief stroke (Transient ischemic attack - TIA)

Respiratory

- Asthma
- COPD
- Respiratory Tuberculosis
- Sleep apnea
- Other:___________________

Female specific:

- Abnormal pap smears
  - Anus
  - Cervix
  - Vaginal
- Genital warts

Male specific:

- Abnormal pap smear anus
- Enlarged Prostate
- Genital warts

Other:

- Anesthetics adverse reaction
- Post Op Bleeding

____
(other problems not listed above)

Females Only: Your Obstetric History (OBGYN Detail)

Are you currently pregnant? **No** **Yes** **Possible** **Number of pregnancies: _________G**

Number of live births: ______P Number of C-Sections: ______ Number of vaginal deliveries: _______

Did you have a tear/laceration during delivery? No Yes Which Pregnancy?____

Did you have an episiotomy during any delivery? No Yes Which Pregnancy?____

Was forcep extraction used for any delivery? No Yes Which Pregnancy?____

Was vacuum extraction used for any delivery? No Yes Which Pregnancy?____

Did you experience Accidental Bowel Leakage (ABL) after any delivery? No Yes Which Pregnancy?____

If yes, how long ? ___________________________________

If yes, did your accidental bowel leakage (ABL) resolve (stop)? No Yes

Did you notice the passage of gas through your vagina after any delivery? No Yes Which Pregnancy?____

Surgery/Procedures - **Please check all that apply and indicate the year the surgery was performed.**

Please check this box if NO past surgeries.

Abdominal Surgery

- Appendectomy (appendix) Year________
- Cholecystectomy (gallbladder) Year________
- Hernia repair Year________
- Gastric bypass Year________
- Abdominoplasty (tummy tuck) Year________

Bowel Surgery

- Colectomy (Removal of a portion of large intestine/colon) Year________
- Small bowel resection (Removal of a portion of small intestine) Year________
- Colostomy Year________
- Ileostomy stoma Year________
- Closure of ileostomy or Colostomy Year________
- Parks pouch (Ileoanal Reservoir) Year________
- Rectal prolapse repair (Abdominal) Year________
- Rectal prolapse repair (Anorectal) Year________

Bowel Incontinence Surgery

- Anal sphincter repair Year________
- Sacral nerve stimulation Year________
- Other______________________ Year________

Anal or Rectal Surgery

- Sphincterotomy (fissure surgery) Year________
- Fistula surgery Year________
- Rectovaginal fistula repair Year________
- Hemorrhoid surgery Year________
- Pilonidal cyst surgery Year________
- Drainage of abscess Year________

Cardiac (heart)/Vascular (blood vessels)

- Aortic aneurysm repair/bypass Year________
- Cardiac pacemaker Year________
- Defibrillator Year________
- Heart stents Year________
- Heart valve placement Year________
- Coronary bypass (CABG) Year________

Transplant Surgery

- Heart Year________
- Lung Year________
- Kidney Year________
- Liver Year________

Orthopedic Surgery

- Hip replacement Year________
- Knee replacement Year________
- Back surgery
  - Cervical Year________
  - Lumbar Year________
  - Thoracic Year________

Female Specific Surgery

- Breast augmentation Year________
- Mastectomy Year________
- Cervical procedure (LEEP/CONE) Year________
- C-section Year________
- Hysterectomy Abdominal Year________
- Hysterectomy Vaginal Year________
- Removal of tubes and ovaries Year________
- Infertility surgery Year________
- Rectocele / Enterocele repair Year________
- Urinary incontinence procedures Year________
- Bladder repair / Cystocele repair Year________
- Sling Year________
- Vaginal prolapse repair Year________

Male Specific Surgery

- Removal of prostate Year________
- Prostate radiation Year________

Miscellaneous Surgery

- Dental / Oral surgery Year________
- Tonsillectomy Year________
- Other______________________ Year________

Other Surgery

- Other______________________ Year________

Personal Habits / Social History

Have you ever used tobacco? No/never Yes Formerly -- Age Quit:___________

Smoking Tobacco Use (former and current):
Cigarette _____ cigarettes/packs per day (circle one)
Cigarillo _____ per day
Cigar _____ per day
Pipe _____ per day

Non-Smoking Tobacco Use (former and current):
Chewing ______ units per day
E-cig ______ units per day
Snuff ______ units per day

Do you consume alcohol? No/Never Yes Formerly (in the past) **Type:** Beer Wine Liquor

How many drinks at a time? 1-2 3-5 6-9 10+ **How often?** ___________________________________

Are you currently employed? No Yes **Occupation:** ____

Have you ever used drugs? No Yes Formerly (in the past)

Have you ever had anal sex? No Yes

HIV Status: Negative Positive Not Tested

Please tell us the race that best describes you: ________________________ **Ethnic background - Hispanic or Latino?** Y / N

Why do we ask this? Some research has shown that some patients may benefit from early or more frequent colorectal cancer screening. Collection of this information helps us make an informed recommendation on screening/tests.

Please tell us your birth sex: _________________ **Please tell us what gender you identify with:** _________________

Your Family History **For any of your family members, please check all that apply.**

Please check this box if NO relevant family history.

If yes, please indicate the family member and if that member was maternal (mother s side) or paternal (father s side).

	Family Member	Maternal or Paternal	Age Diagnosed	Age Deceased
Colon Cancer				
Rectal Cancer				
Celiac Disease				
Colon Polyps				
Crohn s Disease				
Ulcerative Colitis				
Cancer:				
Bile Duct /Gallbladder Cancer				
Bladder Cancer				
Brain Cancer				
Breast Cancer				
Endometrial Cancer				
Gastric (Stomach) Cancer				
Kidney Cancer				
Ovarian Cancer				
Small Intestine/ Small Bowel Cancer				
Uterine Cancer				
Other Cancer Type				
Factor V Leiden Deficiency				
Hemophilia				
Malignant Hyperthemia				
Von Willebrand s Disease				

Diagnostic Studies **Please check all that apply and indicate location and date study was performed.**

Please check this box if NO diagnostic studies have ever been performed.

Colonoscopy	Location/Facility:____________________	Date:__________
Virtual Colonoscopy; CT Colon Imaging	Location/Facility:____________________	Date:__________
Flexible Sigmoidoscopy	Location/Facility:____________________	Date:__________
Stool Testing for Blood (FOBT)	Location/Facility:____________________	Date:__________
Stool Testing for DNA (Cologuard)	Location/Facility:____________________	Date:__________
CT of Abdomen/Pelvis	Location/Facility:____________________	Date:__________
CT-PET	Location/Facility:____________________	Date:__________
Transit Time Study	Location/Facility:____________________	Date:__________
Anal Pap (cytology)	Location/Facility:____________________	Date:__________

Medications/Allergies **Please document any medications you are currently taking.**

Please check if NO current medications

	Name	***Dose (Strength)***	***How Many?***	***How Often?***
Example:	*Aspirin*	*81mg*	*1 tablet*	*Daily*

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

Do you take aspirin? No Yes **If yes, please enter above**

Do you take other blood thinners? No Yes **If yes, please enter above**

Have you taken any steroids (i.e. prednisone or cortisone) within the last 6 months? No Yes

If yes, what kind of steroid? Name: ________________ Dose: ____________ For how long? ______________

When was the last dose?____

Do you have any medication allergies? No Yes If yes, please list below:

1. ________________________________ **What type of reaction?** ______________________________

2. ________________________________ **What type of reaction?** ______________________________

Are you allergic to latex? No Yes **What type of reaction?** ______________________________

Review of Systems Please check any symptoms you are currently experiencing.
Please check this box if you are not experiencing any of these symptoms.

Constitutional

Chills
Fatigue or Weakness
Fever
Recent weight gain of 10 or more lbs.
Recent unplanned weight loss of 10 or more lbs.

Integumentary (Skin)

Itching (pruritus)
Rash

Hearing/Eyes/Vision (HEENT)

Loss of hearing / Diminished hearing
Loss of vision / Change in vision

Neurological

Dizziness / Light headed
Extremity numbness / Tingling
Headaches
Memory loss
Seizures

Respiratory

Chronic or frequent coughing
Shortness of breath

Psychiatric (Mental Health)

Anxiety
Depression

Cardiovascular

Chest pain
Irregular heartbeat (palpitations)

Metabolic/Endocrine

Cold intolerance
Heat intolerance
Excessive thirst or urination (polydipsia)

Gastrointestinal

Abdominal pain
Blood in stools
Change in stools
Constipation
Diarrhea
Accidental Bowel Leakage (ABL)
Loss of appetite
Nausea
Vomiting

Musculoskeletal

Back pain
Joint pain

Genitourinary

Pain with urination (dysuria)
Blood in urine (hematuria)
Urinary incontinence (leakage of urine)

Hematologic/Lymphatic (Bleeding)

Easy bleeding

Reproductive (Females)

Painful intercourse (dyspareunia)

Preferred pharmacy name: ______________________________ **Pharmacy Phone:** ____________________

Pharmacy address:____

In the event of a medical emergency, who may we contact? Name: ____

Relationship: ______________________________________ Phone:_____________________________________