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 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
  - o Cervical
  - o Thoracic
  - o Lumbar
  - o Sacral
  - o Unknown
- □ Stroke (Cerebrovascular accident)
- □ Brief stroke (Transient ischemic attack - TIA)

Respiratory
- □ Asthma
- □ COPD
- □ Respiratory Tuberculosis
- □ Sleep apnea
- □ Other:_____

Female specific:
- □ Abnormal pap smears
  - o Anus
  - o Cervix
  - o 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
  - o Cervical Year_____
  - o Lumbar Year_____
  - o 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: □ Single □ Married □ Partnered

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

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.

Constitutional

Chills	☐ No	☐ Yes
Fatigue or Weakness	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Recent weight gain of 10 or more lbs.	☐ No	☐ Yes
Recent unplanned weight loss of 10 or more lbs.	☐ No	☐ Yes

Hearing/Eyes/Vision (HEENT)

Loss of hearing / Diminished hearing	☐ No	☐ Yes
Loss of vision / Change in vision	☐ No	☐ Yes

Respiratory

Chronic or frequent coughing	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Irregular heartbeat (palpitations)	☐ No	☐ Yes

Gastrointestinal

Abdominal pain	☐ No	☐ Yes
Blood in stools	☐ No	☐ Yes
Change in stools	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Accidental Bowel Leakage (ABL)	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes

Genitourinary

Pain with urination (dysuria)	☐ No	☐ Yes
Blood in urine (hematuria)	☐ No	☐ Yes
Urinary incontinence (leakage of urine)	☐ No	☐ Yes

Reproductive (Females)

Painful intercourse (dyspareunia)	☐ No	☐ Yes

Integumentary (Skin)

Itching (pruritus)	☐ No	☐ Yes
Rash	☐ No	☐ Yes

Neurological

Dizziness / Light headed	☐ No	☐ Yes
Extremity numbness / Tingling	☐ No	☐ Yes
Headaches	☐ No	☐ Yes
Memory loss	☐ No	☐ Yes
Seizures	☐ No	☐ Yes

Psychiatric (Mental Health)

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes

Metabolic/Endocrine

Cold intolerance	☐ No	☐ Yes
Heat intolerance	☐ No	☐ Yes
Excessive thirst or urination (polydipsia)	☐ No	☐ Yes

Musculoskeletal

Back pain	☐ No	☐ Yes
Joint pain	☐ No	☐ Yes

Hematologic/Lymphatic (Bleeding)

Easy bleeding	☐ No	☐ Yes

Preferred pharmacy name: _____ **Pharmacy Phone:** _____

Pharmacy address:_____

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

Relationship: _____ Phone:_____