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
  - 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: □ 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 ☐
- 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:_______________________________________