

Your Name: _____

LONG PATIENT HISTORY FORM

Fill out this form online at www.mycrsal.org

Physician's Notes

Today's Concern

Who sent you to us? _____

What are you being seen for today? _____

Are you experiencing any of the following symptoms? (check all that apply)

- | | | |
|----------------------|-----------------------|----------------------------|
| Anemia | Incontinence of stool | Perianal itching |
| Abdominal pain | Loss of appetite | Bright red rectal bleeding |
| Blood mixed in stool | Recent weight loss | Rectal pain |
| Constipation | Nausea | Vomiting |
| Diarrhea | Other _____ | |

Your Medical History

Have you had or are you being treated for any of the following medical problems? (check all that apply)

- | | | |
|------------------------------|-----------------|--------------------|
| Ulcerative Colitis | COPD/Emphysema | Seizures |
| Crohn's Disease | Asthma | Multiple Sclerosis |
| Colon or Rectal polyps | Sleep Apnea | Stroke |
| Colon or Rectal cancer | Diabetes | Neuropathy |
| Kidney problems | Thyroid Disease | AIDS/HIV Positive |
| Prostate Problems | Gout | Hepatitis |
| Angina | Lipid disorder | Depression |
| Heart Attack | Arthritis | Anxiety |
| High Blood Pressure | Glaucoma | |
| GYN Problems: _____ | | |
| Other Cancer Location: _____ | | |
| Other _____ | | |

Operations

(If yes, check all that apply and date)

- | | | | |
|---------------------------------------|-------------|-----------------------------------|-------------|
| Hysterectomy | When? _____ | Appendix | When? _____ |
| Gallbladder | When? _____ | Hernia Repair | When? _____ |
| Pacemaker/Defibrillator | When? _____ | Tooth extractions or oral surgery | |
| Other surgeries: What and When? _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

Surgical Have you had any major problems with Anesthesia? No Yes
Complications: Have you had any excessive bleeding problems with surgery? No Yes

Gastrointestinal Procedures

Colonoscopy When? _____ Flexible Sigmoidoscopy When? _____
Other: _____

(Females) Your Obstetric History

Are you currently pregnant? _____ Number of pregnancies? _____
Number of C-Sections? _____ Number of live births? _____
Did you experience any vaginal tears during delivery? Yes No

Medications/Allergies

What medications are you currently taking?

<i>Name</i>	<i>Dose (Strength)</i>	<i>How Many?</i>	<i>How Often?</i>
<i>Example: Aspirin</i>	<i>81mg</i>	<i>1 tablet</i>	<i>Daily</i>

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Do you take Aspirin? No Yes How Much? _____

Preferred Pharmacy: _____
Name Address City Phone

Are you allergic to any medications? No Yes What? _____

Are you allergic to latex? No Yes

Your Family History

Do/did any of your family members have?(Grandparents, Father, Mother, Brother, Sister, Children)

Colon or Rectal Polyps: No Yes
Who and at what age? _____

Crohn's Disease: No Yes
Who and at what age? _____

Ulcerative Colitis: No Yes
Who and at what age? _____

Colon Cancer: No Yes
Who and at what age? _____

Rectal Cancer: No Yes
Who and at what age? _____

Other Cancer: No Yes
Who, what kind and at what age? _____

