Colon & Rectal Surgery Associates
Patient Medical Information

Patient's Full Name_____**Date**_____

Height _____**Weight** _____

1. Please list medications you are <u>ALLERGIC</u> to, if none, state none _____
_____

2. Please list your colon and rectal complaint _____
_____

3. How long have you had this problem? _____

4. Past History

a. Past surgical history (list all past surgical procedures and the year performed)
_____
_____

b. Past medical history (list all prior nonsurgical hospitalizations by the reason and year)
_____
_____

c. Have you had a colonoscopy? _____ **When** _____ **Doctor**_____

d. Do you have a personal history of Colon Polyps? _____ **Yes** _____ **No**

d. Do you have any of the following medical problems? __Diabetes __Aids __Arthritis __Lung Disease__Heart Disease __High Blood Pressure __Cancer __Stroke __ Other _____

5. Family History (Do any of the following medical problems run in your family?) __Diabetes __Heart Disease__Lung Disease __High Blood Pressure __Colon Polyps __Cancer (what type(s)?) _____

6. Do you take blood thinners? (Coumadin, Warfarin, Aspirin, Ibuprofen, Motrin, Persantine, Etc.) __Yes __No

7. Please list all medications _____
_____
_____

8. Do you smoke? __Yes __No If yes - packs per day _____ **for** _____ **years**

9. Do you drink alcohol? __Yes __No If yes - How much per week _____

10. Do you take drugs not prescribed by a doctor? __Yes __No

11. Review of systems (Please check any of the following which you have noticed recently)

__Vision Changes
__Difficulty Swallowing
__Sore Throat
__Bleeding from Nose or Mouth
__Cough
__Shortness of Breath
__Increased Thirst for Water
__Heat or Cold Intolerance
__Heart Palpitations
__Chest Pain
__Abdominal Pain
__Nausea
__Vomiting
__Easy Bruising
__Easy Bleeding
__Blood in Urine
__Frequent Urination
__Painful Urination
__Weakness
__Ankle Swelling
__Arm/Leg Weakness or Numbness
__Skin Rash
__Skin Discoloration
__Seizures
__Fainting
__Depression
__Chills
__Fatigue
__Fever
__Weight Loss