METHODIST PHYSICIANS CLINIC

COLON AND RECTAL SURGERY PATIENT HISTORY FORM

Patient Demographics:

Primary Care Provider: _____ Provider phone number:_____
Preferred pharmacy name: _____ Pharmacy Phone: _____
Pharmacy address:_____
Emergency contact/Relationship: _____ Phone:_____

Reason for Visit:

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_____

Medications – 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.				
10.				

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 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?_____o
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? _____
Have you ever had the Pneumococcal Vaccine? ☐ No ☐ Yes Date: _____
Have you had your flu shot this season (Oct.– Mar.)? ☐ No ☐ Yes Date: _____

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Patient Label
NAME:_____DOB:_____
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PERMANENT PART OF MEDICAL RECORD

METHODIST PHYSICIANS CLINIC

Review of Systems – Please check any symptoms you are currently experiencing:

Constitutional			
Chills	☐ No	☐ Yes	
Fever	☐ No	☐ Yes	
General discomfort (Malaise)	☐ No	☐ Yes	
Unplanned weight loss (10+ pounds)	☐ No	☐ Yes	
Weight gain (10+ pounds)	☐ No	☐ Yes	
Hearing/Eyes/Vision (HEENT)	☐ No	☐ Yes	
Double vision	☐ No	☐ Yes	
Ear infections	☐ No	☐ Yes	
Eye pain	☐ No	☐ Yes	
Nasal congestion	☐ No	☐ Yes	
Sinus infection	☐ No	☐ Yes	
Sore throat	☐ No	☐ Yes	
Respiratory	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes	
Difficult or labored breathing (dyspnea)	☐ No	☐ Yes	
Frequent cough	☐ No	☐ Yes	
Pleuritic pain	☐ No	☐ Yes	
Wheezing	☐ No	☐ Yes	
Cardiovascular	☐ No	☐ Yes	
Chest pain	☐ No	☐ Yes	
Swelling in extremities	☐ No	☐ Yes	
Irregular heartbeat (palpitations)	☐ No	☐ Yes	
Gastrointestinal	☐ No	☐ Yes	
Abdominal pain	☐ No	☐ Yes	
Change in stools	☐ No	☐ Yes	
Constipation	☐ No	☐ Yes	
Diarrhea	☐ No	☐ Yes	
Trouble swallowing (dysphagia)	☐ No	☐ Yes	
Heartburn	☐ No	☐ Yes	
Vomiting of blood (Hematemesis)	☐ No	☐ Yes	
Blood in stools (Hematochezia)	☐ No	☐ Yes	
Loss of appetite	☐ No	☐ Yes	
Black tarry stools	☐ No	☐ Yes	
Nausea	☐ No	☐ Yes	
Reflux	☐ No	☐ Yes	
Vomiting	☐ No	☐ Yes	
Accidental bowel Leakage (ABL)	☐ No	☐ Yes	

Reproductive (Females Only)		
Breast lumps	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Vaginal discharge	☐ No	☐ Yes
Painful intercourse (dyspareunia)	☐ No	☐ Yes
Reproductive (Males Only)	☐ No	☐ Yes
Penile discharge	☐ No	☐ Yes
Sexual dysfunction	☐ No	☐ Yes
Metabolic/Endocrine	☐ No	☐ Yes
Cold intolerance	☐ No	☐ Yes
Excessive thirst	☐ No	☐ Yes
Heat intolerance	☐ No	☐ Yes
Gynecomastia (males)	☐ No	☐ Yes
Neurological	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Extremity numbness / Tingling	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Vertigo	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Psychiatric (Mental Health)	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Increased stress	☐ No	☐ Yes
Integumentary (Skin)	☐ No	☐ Yes
Hives	☐ No	☐ Yes
Itching (pruritus)	☐ No	☐ Yes
Rash	☐ No	☐ Yes
Musculoskeletal	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Muscle pain (Myalgia)	☐ No	☐ Yes
Joint pain	☐ No	☐ Yes
Hematologic /Lymphatic (Bleeding)	☐ No	☐ Yes
Easy bleeding	☐ No	☐ Yes
Easy bruising	☐ No	☐ Yes
Lymphadenopathy	☐ No	☐ Yes

Patient Label

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PERMANENT PART OF MEDICAL RECORD

METHODIST PHYSICIANS CLINIC

Review of Systems (cont.) – Please check any symptoms you are currently experiencing:

Genitourinary	☐ No ☐ Yes		
Pain with urination	☐ No ☐ Yes	**Immunologic**	☐ No ☐ Yes
Blood in Urine (hematuria)	☐ No ☐ Yes	Food allergies	☐ No ☐ Yes
Urinary Frequency	☐ No ☐ Yes	Seasonal allergies	☐ No ☐ Yes
Urinary incontinence (leakage of urine)	☐ No ☐ Yes		
Urinary retention	☐ No ☐ Yes		

Problem List – Check the boxes below for any conditions you have been diagnosed and/or are being treated for.

☐ Please check if Nothing Applicable

Blood Problems
- ☐ Anemia *D64.9*
- ☐ Blood Clots (DVT/Embolism) *Z86.718*
- ☐ Bleeding disorder *D69.9*
- ☐ Clotting disorder *D68.9*

Cardiac Vascular
- ☐ Angina (chest pain) *I48.91*
- ☐ Arrhythmia (heart rhythm problems) *I49.9*
- ☐ Atrial fibrillation *I48.91*
- ☐ Heart failure *I50.9*
- ☐ Hyperlipidemia (high cholesterol) *E78.5*
- ☐ Hypertension (high blood pressure) *I10*
- ☐ Malignant hyperthermia *T88.3*
- ☐ Past heart attack *I25.2*
- ☐ Peripheral vascular disease: (Blood vessel problems in legs) *I73.9*

Cancer
- ☐ Anal cancer *C21.0*
- ☐ Bladder cancer *C67.9*
- ☐ Breast cancer (Female) *C50.919*
- ☐ Breast cancer (Male) *C50.929*
- ☐ Cervical cancer *C53.9*
- ☐ Colon cancer *C18.9*
- ☐ Kidney cancer *C64.9*
- ☐ Ovarian cancer *C56.9*
- ☐ Penile cancer *C60.9*
- ☐ Prostate cancer *C61*
- ☐ Rectal cancer *C20*
- ☐ Small bowel cancer *C17.9*
- ☐ Stomach cancer *C16.9*
- ☐ Urinary tract cancer *C68.9*
- ☐ Uterine (endometrial) cancer *C55*
- ☐ Vulva cancer *C51.9*
- ☐ Other cancer: _____

Eyes
- ☐ Glaucoma *H40.9*
- ☐ Vision loss *H54.7*

Endocrine
- ☐ Adrenal disease *E27.9*
- ☐ Diabetes *E13.9*
- ☐ Hyperthyroidism (high thyroid disease) *E05.90*
- ☐ Hypothyroidism (low thyroid disease) *E03.9*

Gastrointestinal
- ☐ Accidental bowel leakage *R15.9*
- ☐ Anal/Rectal trauma/injury *S36.60*
- ☐ Celiac disease (gluten sensitive) K*90.0*
- ☐ Colon/Rectal polyps *Z86.010*
- ☐ Crohn's disease *K50.90*
- ☐ IBS (Irritable bowel syndrome) *K58.9*
- ☐ Ulcerative colitis *K51.919*

Infection
- ☐ Hepatitis *Z22.50*
- ☐ MRSA *Z22.322*
- ☐ VRE *Z22.39*

Kidney/Urinary
- ☐ Poor kidney function *N28.9*
- ☐ Renal failure *N18.9*
- ☐ Urinary incontinence (leakage of urine) *R32*

Mental Health
- ☐ Anxiety *F41.9*
- ☐ Depression *F32.9*

Musculoskeletal
- ☐ Arthritis *M19.90*
- ☐ Back problems *M53.9*
- ☐ Gout *M10.9*
- ☐ Pelvic fracture *S32.9XXs*

Neurological
- ☐ Multiple sclerosis *G35*
- ☐ Neuropathy *G62.9*
- ☐ Seizures *R56.9*
- ☐ Spinal cord injury
  - ○ Cervical *S14.109A*
  - ○ Thoracic *S24.109A*
  - ○ Lumbar *S34.209A*
  - ○ Sacral *S34.139A*
  - ○ Unknown *Z87.828*
- ☐ Stroke (Cerebrovascular accident) *Z86.73*
- ☐ Brief stroke (Transient ischemic attack-TIA) *Z86.73*

Respiratory
- ☐ Asthma *J45.998*
- ☐ COPD *J44.9*
- ☐ Sleep apnea *G47.30*
- ☐ Other:_____

Female specific
- ☐ Abnormal pap smears
  - ○ Anus *R85.619*
  - ○ Cervix *R87.619*
  - ○ Vaginal *R87.629*
- ☐ Genital warts *A63.0*

Male specific
- ☐ Abnormal Pap smear anus *R85.619*
- ☐ Enlarged Prostate *N40.0*
- ☐ Genital warts *A63.0*

Other medical problem not listed above:

_____
_____
_____
_____
_____

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Females Only: Your Obstetric History (OBGYN Detail)

Are you 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 deliver?	☐ No	☐ Yes	Which Pregnancy?____
Was forceps 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	Which Pregnancy?____
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 (weight loss surgery) 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_____

Transplant Surgery

- ☐ Heart Year_____
- ☐ Lung Year_____
- ☐ Kidney Year_____
- ☐ Liver Year_____

Orthopedic Surgery

- ☐ Hip replacement Year_____
- ☐ Knee replacement Year_____
- ☐ Back surgery Year_____
  - ○ Cervical Year_____
  - ○ Lumbar Year_____
  - ○ Thoracic Year_____

Female Specific Surgery

- ☐ Breast augmentation Year_____
- ☐ Mastectomy Year_____
- ☐ Cervical procedure 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 procedure Year_____
- ☐ Bladder repair/cystocele repair Year_____
- ☐ Sling Year_____
- ☐ Vaginal prolapse repair Year_____

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Surgery/Procedures (cont.)

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/Aortic bypass Year_____
- ☐ Cardiac pacemaker Year_____
- ☐ Defibrillator Year_____
- ☐ Heart stents Year_____
- ☐ Heart valve placement Year_____
- ☐ Coronary bypass (CABG) 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_____
- ☐ Other_____ Year_____

Have you had any major problems with anesthesia? ☐ No ☐ Yes _____

Have you had any excessive bleeding problems with surgery? ☐ No ☐ Yes _____

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:_____
☐ Flexible Sigmoidoscopy	Location/Facility:_____	Date:_____
☐ CT of Abdomen/Pelvis	Location/Facility:_____	Date:_____
☐ CT-PET	Location/Facility:_____	Date:_____
☐ Transit Time Study	Location/Facility:_____	Date:_____
☐ Mammogram (Females)	Location/Facility:_____	Date:_____

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 relationship of 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				
Bile Duct/Gallbladder Cancer				
Bladder Cancer				
Brain Cancer				

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Family History – (cont.)	**Family Member**	**Maternal or Paternal**	**Age Diagnosed**	**Age Deceased**
Breast Cancer				
Endometrial Cancer				
Gastric (Stomach) Cancer				
Kidney Cancer				
Ovarian Cancer				
Small Intestine/Small Bowel Cancer				
Uterine Cancer				
Other Cancer				
Factor V Leiden Deficiency				
Hemophilia				
Malignant Hyperthermia				
Von Willebrand's Disease				

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
- ☐ Cigarillo _____ per day
- ☐ Cigar _____ per day
- ☐ Pipe _____ per day

Non-Smoking Tobacco Use (former and current):

- ☐ Chewing _____ units per day
- ☐ E-cig _____ per day
- ☐ Snuff _____ per day

Do you consume alcohol? ☐ No/Never ☐ Yes ☐ Formerly *(in the past)* ☐ Beer ☐ Liquor ☐ Wine ☐ All Types
How many drinks per day? ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐10+ How often?_____
Do you consume caffeine? ☐ No/Never ☐ Yes Type: Coffee Soda Energy drinks
How many drinks per day? ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐10+ How often?_____
Are you currently: ☐ Single ☐ Married ☐ Partnered
Are you currently employed? ☐ No ☐ Yes ☐ Fulltime ☐ Part-time ☐ Disabled
Occupation (required): _____
Retired? ☐ Yes ☐ No Previous occupation:_____
Have you ever used illicit drugs? ☐ No/Never ☐ Yes ☐ Formerly (in the past) Type:_____
Have you ever had anal sex? ☐ No/Never ☐ Yes
HIV Status: ☐ Negative ☐ Positive ☐ Not Tested

Communicable Disease – *All patients are being screened for communicable diseases*

Have you lived or traveled to a country with widespread Ebola virus transmission?	☐ No	☐ Yes
Have you had contact with an individual with confirmed Ebola Virus Disease in the last 21 days?	☐ No	☐ Yes
Do you have tuberculosis (TB)?	☐ No	☐ Yes
Do you have measles?	☐ No	☐ Yes
Do you have chickenpox or shingles?	☐ No	☐ Yes
Do you have any other infectious diseases (including MRSA, C.Diff, VRE, CRE, CRKP)	☐ No	☐ Yes

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