



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: _____
FIN: _____	MRN: _____

PERMANENT PART OF MEDICAL RECORD



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

Constitutional

Chills	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes
General discomfort (Malaise)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Unplanned weight loss (10+ pounds)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weight gain (10+ pounds)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Hearing/Eyes/Vision (HEENT)

Double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ear infections	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nasal congestion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sinus infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sore throat	<input type="checkbox"/> No <input type="checkbox"/> Yes

Respiratory

Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Difficult or labored breathing (dyspnea)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Frequent cough	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pleuritic pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes

Cardiovascular

Chest pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swelling in extremities	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular heartbeat (palpitations)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Gastrointestinal

Abdominal pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Change in stools	<input type="checkbox"/> No <input type="checkbox"/> Yes
Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Trouble swallowing (dysphagia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heartburn	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vomiting of blood (Hematemesis)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blood in stools (Hematochezia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Loss of appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes
Black tarry stools	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nausea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Reflux	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes
Accidental bowel Leakage (ABL)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Reproductive (Females Only)

Breast lumps	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breast pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vaginal discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes
Painful intercourse (dyspareunia)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Reproductive (Males Only)

Penile discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sexual dysfunction	<input type="checkbox"/> No <input type="checkbox"/> Yes

Metabolic/Endocrine

Cold intolerance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive thirst	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heat intolerance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gynecomastia (males)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Neurological

Dizziness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes
Extremity numbness / Tingling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tremors	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vertigo	<input type="checkbox"/> No <input type="checkbox"/> Yes
Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes

Psychiatric (Mental Health)

Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Increased stress	<input type="checkbox"/> No <input type="checkbox"/> Yes

Integumentary (Skin)

Hives	<input type="checkbox"/> No <input type="checkbox"/> Yes
Itching (pruritus)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes

Musculoskeletal

Back pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Muscle pain (Myalgia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Joint pain	<input type="checkbox"/> No <input type="checkbox"/> Yes

Hematologic /Lymphatic (Bleeding)

Easy bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes
Easy bruising	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lymphadenopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes

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PERMANENT PART OF MEDICAL RECORD



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

Genitourinary

- ☐ No ☐ Yes
- Pain with urination ☐ No ☐ Yes
- Blood in Urine (hematuria) ☐ No ☐ Yes
- Urinary Frequency ☐ No ☐ Yes
- Urinary incontinence (leakage of urine) ☐ No ☐ Yes
- Urinary retention ☐ No ☐ Yes

Immunologic

- ☐ No ☐ Yes
- Food allergies ☐ No ☐ Yes
- Seasonal allergies ☐ 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) *K90.0*
- ☐ 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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PERMANENT PART OF MEDICAL RECORD

Patient Label

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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 _____

Transplant Surgery

- ☐ Heart Year _____
- ☐ Lung Year _____
- ☐ Kidney Year _____
- ☐ Liver 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 _____

Orthopedic Surgery

- ☐ Hip replacement Year _____
- ☐ Knee replacement Year _____
- ☐ Back surgery Year _____
 - ☐ Cervical Year _____
 - ☐ Lumbar Year _____
 - ☐ Thoracic Year _____

Bowel Incontinence Surgery

- ☐ Anal sphincter repair Year _____
- ☐ Sacral nerve stimulation Year _____
- ☐ Other _____ 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/Enterocoele 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**

- | | |
|---|------------|
| <input type="checkbox"/> Sphincterotomy (fissure surgery) | Year _____ |
| <input type="checkbox"/> Fistula surgery | Year _____ |
| <input type="checkbox"/> Rectovaginal fistula repair | Year _____ |
| <input type="checkbox"/> Hemorrhoid surgery | Year _____ |
| <input type="checkbox"/> Pilonidal cyst surgery | Year _____ |
| <input type="checkbox"/> Drainage of abscess | Year _____ |

Cardiac (heart)/Vascular (blood vessels)

- | | |
|---|------------|
| <input type="checkbox"/> Aortic aneurysm repair/Aortic bypass | Year _____ |
| <input type="checkbox"/> Cardiac pacemaker | Year _____ |
| <input type="checkbox"/> Defibrillator | Year _____ |
| <input type="checkbox"/> Heart stents | Year _____ |
| <input type="checkbox"/> Heart valve placement | Year _____ |
| <input type="checkbox"/> Coronary bypass (CABG) | Year _____ |

Male Specific Surgery

- | | |
|--|------------|
| <input type="checkbox"/> Removal of prostate | Year _____ |
| <input type="checkbox"/> Prostate radiation | Year _____ |

Miscellaneous Surgery

- | | |
|--|------------|
| <input type="checkbox"/> Dental/Oral surgery | Year _____ |
| <input type="checkbox"/> Tonsillectomy | Year _____ |
| <input type="checkbox"/> Other _____ | Year _____ |

Other Surgery

- | | |
|--------------------------------------|------------|
| <input type="checkbox"/> Other _____ | Year _____ |
| <input type="checkbox"/> 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

- | | | |
|---|--------------------------|-------------|
| <input type="checkbox"/> Colonoscopy | Location/Facility: _____ | Date: _____ |
| <input type="checkbox"/> Flexible Sigmoidoscopy | Location/Facility: _____ | Date: _____ |
| <input type="checkbox"/> CT of Abdomen/Pelvis | Location/Facility: _____ | Date: _____ |
| <input type="checkbox"/> CT-PET | Location/Facility: _____ | Date: _____ |
| <input type="checkbox"/> Transit Time Study | Location/Facility: _____ | Date: _____ |
| <input type="checkbox"/> 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).

<u>Family Member</u>	<u>Maternal or Paternal</u>	<u>Age Diagnosed</u>	<u>Age Deceased</u>
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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<u>Family History – (cont.)</u>	<u>Family Member</u>	<u>Maternal or Paternal</u>	<u>Age Diagnosed</u>	<u>Age Deceased</u>
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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