



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

Genitourinary

- No Yes

Pain with urination
Blood in Urine (hematuria)
Urinary Frequency
Urinary incontinence (leakage of urine)
Urinary retention

- No Yes

Immunologic

- Food allergies
- Seasonal allergies

- No Yes
- No Yes
- 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

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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 delivery?

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

<input type="checkbox"/> Appendectomy (appendix)	Year _____
<input type="checkbox"/> Cholecystectomy (gallbladder)	Year _____
<input type="checkbox"/> Hernia repair	Year _____
<input type="checkbox"/> Gastric bypass (weight loss surgery)	Year _____
<input type="checkbox"/> Abdominoplasty (tummy tuck)	Year _____

Transplant Surgery

<input type="checkbox"/> Heart	Year _____
<input type="checkbox"/> Lung	Year _____
<input type="checkbox"/> Kidney	Year _____
<input type="checkbox"/> Liver	Year _____

Bowel Surgery

<input type="checkbox"/> Colectomy (removal of a portion of large intestine/colon)	Year _____
<input type="checkbox"/> Small bowel resection (removal of a portion of small intestine)	Year _____
<input type="checkbox"/> Colostomy	Year _____
<input type="checkbox"/> Ileostomy stoma	Year _____
<input type="checkbox"/> Closure of ileostomy or colostomy	Year _____
<input type="checkbox"/> Parks pouch (ileoanal reservoir)	Year _____
<input type="checkbox"/> Rectal prolapse repair (abdominal)	Year _____
<input type="checkbox"/> Rectal prolapse repair (anorectal)	Year _____

Orthopedic Surgery

<input type="checkbox"/> Hip replacement	Year _____
<input type="checkbox"/> Knee replacement	Year _____
<input type="checkbox"/> Back surgery	Year _____
<input type="radio"/> Cervical	Year _____
<input type="radio"/> Lumbar	Year _____
<input type="radio"/> Thoracic	Year _____

Bowel Incontinence Surgery

<input type="checkbox"/> Anal sphincter repair	Year _____
<input type="checkbox"/> Sacral nerve stimulation	Year _____
<input type="checkbox"/> Other _____	Year _____

Female Specific Surgery

<input type="checkbox"/> Breast augmentation	Year _____
<input type="checkbox"/> Mastectomy	Year _____
<input type="checkbox"/> Cervical procedure	Year _____
<input type="checkbox"/> C-section	Year _____
<input type="checkbox"/> Hysterectomy – Abdominal	Year _____
<input type="checkbox"/> Hysterectomy – Vaginal	Year _____
<input type="checkbox"/> Removal of tubes and ovaries	Year _____
<input type="checkbox"/> Infertility surgery	Year _____
<input type="checkbox"/> Rectocele/Enterocle repair	Year _____
<input type="checkbox"/> Urinary incontinence procedure	Year _____
<input type="checkbox"/> Bladder repair/cystocele repair	Year _____
<input type="checkbox"/> Sling	Year _____
<input type="checkbox"/> 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

<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?	<input type="checkbox"/> No/Never	<input type="checkbox"/> Yes	<input type="checkbox"/> Formerly – Age Quit: _____
Smoking tobacco Use (former and current):	Non-Smoking Tobacco Use (former and current):		
<input type="checkbox"/> Cigarette _____ cigarettes/packs per day	<input type="checkbox"/> Chewing _____ units per day		
<input type="checkbox"/> Cigarillo _____ per day	<input type="checkbox"/> E-cig _____ per day		
<input type="checkbox"/> Cigar _____ per day	<input type="checkbox"/> Snuff _____ per day		
<input type="checkbox"/> Pipe _____ per day			
Do you consume alcohol?	<input type="checkbox"/> No/Never	<input type="checkbox"/> Yes	<input type="checkbox"/> Formerly (in the past) <input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine <input type="checkbox"/> All Types
How many drinks per day?	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6-9 <input type="checkbox"/> 10+ How often? _____
Do you consume caffeine?	<input type="checkbox"/> No/Never	<input type="checkbox"/> Yes	Type: Coffee Soda Energy drinks
How many drinks per day?	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> 6-9 <input type="checkbox"/> 10+ How often? _____
Are you currently:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Partnered
Are you currently employed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Fulltime <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled
Occupation (required): _____			
Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous occupation: _____		
Have you ever used illicit drugs?	<input type="checkbox"/> No/Never	<input type="checkbox"/> Yes	<input type="checkbox"/> Formerly (in the past) Type: _____
Have you ever had anal sex?	<input type="checkbox"/> No/Never	<input type="checkbox"/> Yes	
HIV Status:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had contact with an individual with confirmed Ebola Virus Disease in the last 21 days?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have tuberculosis (TB)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have measles?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have chickenpox or shingles?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any other infectious diseases (including MRSA, C.Diff, VRE, CRE, CRKP)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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