Name: _____

Date of birth: _____

Date: _____

METHODIST PHYSICIANS CLINIC

COLON AND RECTAL SURGERY
THE COLONOSCOPY CENTER

PATIENT HISTORY FORM

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? 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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Name: _____ DOB:_____

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

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

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

Immunologic ☐ No ☐ Yes
- Food allergies ☐ No ☐ Yes
- Seasonal allergies ☐ No ☐ Yes

Name: _____ DOB:_____

Problem List – Please check the appropriate boxes if you have been diagnosed and/or are being treated for any of the following conditions.

☐ 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 attach *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*
- ☐ Hyperthyroidism (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:

_____

_____

_____

_____

_____

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?____

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Name: _____ DOB:_____

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_____

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_____

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_____

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 _____

Name: _____ DOB:_____

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:_____
☐ Anal Pap (cytology)	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				

Cancer:

- Bile Duct/Gallbladder Cancer_____
- Bladder Cancer_____
- Brain Cancer_____
- 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 Hyperthemia_____

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

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Name: _____ DOB:_____

Do you consume alcohol? ☐ No/Never ☐ Yes ☐ Formerly (in the past)
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)
Have you ever had anal sex? ☐ No/Never ☐ Yes
HIV Status: ☐ Negative ☐ Positive ☐ Not Tested

Communicable Disease – Please provider the information below:
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

Patient Demographics:

Primary Care Provider: _____ **Provider phone number:**_____

Preferred pharmacy name: _____ **Pharmacy Phone:**_____

Pharmacy address:_____

In the event of a medical emergency, who may we contact: Name:_____

Relationship:_____ **Phone:**_____