Capitol Colorectal Health Information Form

Patient Name: _____ D.O.B.: _____ Age: _____ Date:_____
Preferred Pharmacy_____ Location_____ Phone#_____
Referring Physician: _____ Cardiologist: _____
Primary Care Physician: _____ OB/GYN: _____
Gastroenterologist: _____

Main Reason for office visit: _____

Have you completed a living will or durable power of attorney for health care? □ No □Yes

Past Medical History-Have you ever had the Following: **___No Medical History**

□ Psoriasis or other skin disorder	□ Kidney disease	□ Diabetes
□ High blood pressure or hypertension	□ Thyroid problems	□ Anemia
□ Irregular heartbeat	□ Phlebitis or blood clots	□ Glaucoma
□ Mitral valve prolapse	□ Bleeding tendency	□ Jaundice
□ Heart murmur	□ Rheumatoid arthritis	□ Peptic ulcer
□ Heart attack or angina	□ Osteoarthritis	□ Colitis
□ Emphysema	□ Stroke or paralysis	□ Asthma
□ Chronic bronchitis	□ Diverticulitis	□ Colon polyps
□ Rheumatic fever	□ Seizures or epilepsy	□ Herpes

Cancer: (specify type): _____

Past Surgical History and provide date:

_____ _____
_____ _____
_____ _____

Have you had a colonoscopy or barium enema before: □ No □ Yes
If yes, list physician who performed the examination and when: _____
Findings: (check any that apply) □ polyps □ colitis □ hemorrhoids □ other
_____

Medications: Please List **ALL Medications** you are currently taking
Please use other side if necessary _____
_____
_____

Do you take a **blood thinner** or **anticoagulant medication? __**YES **___**NO (please circle) Coumadin/Warfarin / Plavix /Aspirin / Other
List your **ALLERGIES** and type of **REACTION: _____**
_____
_____**ALLERGIC TO LATEX: ___YES ___NO Reaction_____**

FAMILY MEDICAL HISTORY:
Please indicate family members that have or had: □ Colon and/or Rectal Cancer □ Polyps □ Ulcerative Colitis or □ Crohn's disease
If applies, list each member, how they are related and age diagnosed:
_____
Please indicate family members with medical conditions □Diabetes □Heart Disease □Hypertension □Stroke □Seizures □other cancers
If applies, list each member, how they are related and age diagnosed with such conditions:
_____

For Women only:
Pregnancies _____ # Vaginal deliveries _____ # C-sections _____

Are you pregnant or breast feeding?	Yes □ No □
If still menstruating, are your periods regular and without excessive pain or bleeding?	Yes □ No □
Have you had a hysterectomy (removal of uterus)?	Yes □ No □
If you still have your uterus, was your last PAP smear normal?	Yes □ No □
Do you still have one or both ovaries?	Yes □ No □
Have you ever been told by your doctor that you have endometriosis?	Yes □ No □

SOCIAL HISTORY:
What is your current profession? _____ Marital Status: □ Married □ Divorced □ Single □ Widowed
Do you use tobacco? □ No □Yes, how many packs/day? _____ Do you drink alcohol? □ No □Yes, how many drinks/week? _____
Do you use a controlled substance? □ No □Yes, please list? _____

REVIEW OF SYSTEMS (*Please further describe any symptoms below or on back)*:

General	□ No □Yes Weight loss, how much? □ No □Yes Recurrent fever	Gastrointestinal	□ No □Yes Bowel habit change □ No □Yes Bleeding □ No □Yes Abdominal pain □ No □Yes Constipation □ No □Yes Diarrhea □ No □Yes Nausea or vomiting □ No □Yes Peptic ulcer disease □ No □Yes Anal Pain □ No □Yes Anal itching	Eyes	□ No □Yes Vision Change □ No □Yes Cataracts/ Glaucoma
Ear, Nose and Throat	□ No □Yes Dental problems □ No □Yes Bleeding gums □ No □Yes Difficulty swallowing			Neurological	□ No □Yes Stroke/Seizure □ No □Yes Fainting/blackouts □ No □Yes Loss of function
Cardiovascular	□ No □Yes High blood pressure □ No □Yes Chest pain/heart attack □ No □Yes Irregular heart beat □ No □Yes Palpitations □ No □Yes Swollen feet □ No □Yes Abnormal stress test □ No □Yes **Pacemaker** □ No □Yes **Defibrillator** (need card) □ No □Yes Heart murmur □ No □Yes Abnormal heart valve □ No □Yes High cholesterol	Endocrine	□ No □Yes Diabetes □ No □Yes Thyroid problems □ No □Yes Steroid use	Oncologic	□ No □Yes Chemotherapy □ No □Yes Radiation
		Genitourinary	□ No □Yes Painful urination □ No □Yes Blood in urine □ No □Yes Urinary incontinence □ No □Yes Urinary frequency □ No □Yes Frequent bladder infections	Psychiatric	□ No □Yes Anxiety/Mood swings □ No □Yes Depression □ No □Yes Joint pain/ Arthritis
				HIV AIDS Herpes	□ No □Yes □ Not Tested? □ No □Yes □ No □Yes
		Dermatologic	□ No □Yes Rash/Ulcer □ No □Yes Easy bruising □ No □Yes Skin cancer	Additional Comments:	
Respiratory	□ No □Yes Shortness of breath □ No □Yes Emphysema □ No □Yes Cough with sputum □ No □Yes Asthma	Hematologic	□ No □Yes Anemia □ No □Yes Bleeding disorder		

I have reviewed the above review of systems with the patient today: _____