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Capitol ColoRectal

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Ph 517-372-0500
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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 today's visit: _____

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

PAST MEDICAL HISTORY: check if you have ever had any of the following: or **No Medical History** ____

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

PAST SURGICAL HISTORY: and provide dates:

_____ _____
_____ _____
_____ _____

Have you had a colonoscopy or barium enema in the past: Yes □ No □
If yes, list physician and date of examination: _____
Findings: (check all that apply) □ polyps □ colitis □ hemorrhoids □ other _____

MEDICATIONS: list **all medications** you are currently taking: (please use other side if necessary)

_____
_____
_____

Do you take a blood thinner or anticoagulant medication? Yes □ No □ (circle) Coumadin/Warfarin/Plavix/Aspirin /Other

List your **ALLERGIES** and type of **REACTION**: _____
_____

Are you allergic to latex? Yes □ No □ **Reaction:** _____

FAMILY MEDICAL HISTORY: please indicate family members that have or have had:
□ Colon and/or Rectal Cancer □ Polyps □ Ulcerative Colitis or □ Crohn's Disease
List each family member, how related and age diagnosed: _____
_____
□ Diabetes □ Heart Disease □ Hypertension □ Stroke □ Seizures □ Other Cancers
List each family member, how related and age diagnosed: _____
_____

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

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Patient's Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS

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				