COLON & RECTAL SPECIALISTS, LTD.

NEW PATIENT MEDICAL AND SURGICAL HISTORY

Date ________ Patient's Name ____________________ Age ______ Height ______ Weight ______

Pharmacy Information

Name of Pharmacy ____________________ Telephone Number __________ Fax Number __________

Address ____________________ City ______________ State ______ Zip ________

Present Complaint or Illness ____

____

Previous Surgical History

	Name / Type of Surgery	Date of Surgery
1.		
2.		
3.		
4.		

Previous Illnesses or Hospitalizations

	Illnesses/Hospitalization	Date of Hospitalization
1.		
2.		
3.		

	Current Medications (include over the counter)	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DRUG ALLERGIES ____

____

Medical History

Diabetes	No	Yes
Hypertension / High Blood Pressure	No	Yes
Congestive Heart Failure	No	Yes
Stroke	No	Yes
Heart Attack	No	Yes

Females Only

Number of Pregnancies ______________

Number of Miscarriages ______________

Date of Last Menstrual Cycle ______________

Social History

Use of Alcohol		Use of Tobacco	Dates >	Start	Stop	Use of Drugs	
Never		Never Smoker ______	Former Smoker			Never	
Rarely		Current Every Day Smoker, Packs Per Day				Type / Frequency	
Moderate		Current Some Day Smoker, Packs Per Day					
Daily		Heavy Smoker, Pack Per Day					
		Light Smoker, Packs Per Day					

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Family Medical History

	Current Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			

Complete System Review

Constitutional Symptoms

Good, General Health		No	Yes
Recent Weight Loss	lbs	No	Yes
Recent Weight Gain	lbs	No	Yes
Fevers		No	Yes
Headaches		No	Yes

Cardiovascular

Chest Pain or Angina	No	Yes
Swelling of Feet or Ankles	No	Yes
Palpitations or Skipped Beats	No	Yes

Neurologic

Convulsions or Seizures	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

Hematologic

Bruising Tendency	No	Yes
Bleeding Gums	No	Yes
Anemia	No	Yes
Easy Bleeding	No	Yes

Psychiatric

Trouble Sleeping	No	Yes
Confused Thoughts	No	Yes
Feeling Depressed	No	Yes

Gastrointestinal

Change in Bowel Movements	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Abdominal Pain	No	Yes
Heartburn	No	Yes
Rectal Bleeding	No	Yes

Genitourinary

Burning or Painful Urination	No	Yes
Difficulty Urinating	No	Yes
Frequent Urination	No	Yes
Change in Color of Urine	No	Yes

Respiratory

Chronic or Frequent Coughs	No	Yes
Shortness of Breath	No	Yes
Asthma or Wheezing	No	Yes

Musculoskeletal

Joint Pains	No	Yes
Painful Swollen Joints	No	Yes
Chronically Sore Muscles	No	Yes

Endocrine

Chronic Fatigue	No	Yes
Heat Intolerance	No	Yes
Cold Intolerance	No	Yes
Dry, Flaky Skin	No	Yes
Sleep Apnea	No	Yes

Signature ______________________________ Date ______________