

Name: _____

Age: _____ Date of Appointment: _____

Who were you referred by? _____

Your primary care physician is Dr. _____

Please name your other doctors. _____

What is your main complaint and reason for your visit? _____

Circle YES or NO and write in answers.

Do you have anal or rectal bleeding? ----- YES or NO

If yes, please circle the color. **Bright red** **Maroon or wine** **Black like tar**

Where do you see the blood? Circle one or more:

On the tissue **In the toilet water** **On the surface of the stool** **Mixed in the stool**

How frequently do you see the blood? _____

When did this anal or rectal bleeding start? _____

When was the last time you had anal or rectal bleeding? _____

Do you have anal or rectal pain? ----- YES or NO

If yes, when did you first experience this pain? _____

Please describe the pain. _____

Does something protrude, bulge or stick out from the anus? ----- YES or NO

If yes, can you or do you push the protrusion back in? _____

Do you have anal itching? ----- YES or NO

If yes, when is the itching worst? _____

Do you scratch a lot? ----- YES or NO

Do you have any anal discharge, drainage, leakage, or staining of your clothes? ----- YES or NO

If yes, describe. _____

Name: _____

How would you describe your bowel movements?

Circle one or more: Watery Loose Fragmented Soft Hard

How often do you move your bowels? _____

Do you have accidental bowel leakage of gas (flatus)? ----- YES or NO

If yes, how frequently? _____

Do you have accidental bowel leakage of liquid stool? ----- YES or NO

If yes, how frequently? _____

Do you have accidental bowel leakage of solid stool? ----- YES or NO

If yes, how frequently? _____

Do you get abdominal pain? ----- YES or NO

If yes, please describe. _____

Have your bowel habits changed recently? ----- YES or NO

If yes, please describe. _____

Have your stools become narrow? ----- YES or NO

Has your appetite diminished? ----- YES or NO

Have you lost weight? ----- YES or NO

If yes, how many pounds? _____ Over how many months? _____

Was this intentional? _____

Have you tried any medicines, diet supplements, laxatives, creams or

suppositories to alleviate your symptoms? ----- YES or NO

If yes, describe. _____

Are you currently using any of these remedies? ----- YES or NO

If yes, which ones? _____

Are these remedies helping? _____

Name: _____

Have you ever had a sigmoidoscopy (an examination of your lower colon and rectum by means of a lighted tubular instrument)? ----- YES or NO

If yes, when? _____

If yes, what was found? _____

Have you ever had a colonoscopy (an examination of your entire colon by means of a lighted tubular instrument)? ----- YES or NO

If yes, when? _____

If yes, what was found? _____

Have you ever had a barium enema (an examination by a radiologist wherein barium, a white chalky contrast material, is infused into the rectum and x-rays are taken)? ----- YES or NO

If yes, when? _____

If yes, what was found? _____

PAST MEDICAL HISTORY

Have you ever had any operations on the colon or rectum? ----- YES or NO

If yes, when? _____

If yes, what was done? _____

Please circle YES or NO depending on whether or not you have had the condition.

Autoimmune disease ----- YES or NO

Blood transfusions ----- YES or NO

Bleeding disorder (for example, hemophilia) ----- YES or NO

If yes, describe: _____

Cancer ----- YES or NO

If yes, what type? _____

Chronic lung disease (asthma, emphysema, or bronchitis) ----- YES or NO

If yes, for how long? _____

Name: _____

Diabetes ----- YES or NO

If yes, for how long? _____

Heart disease ----- YES or NO

If yes, describe and give dates. _____

Hepatitis or jaundice ----- YES or NO

Hypertension (high blood pressure) ----- YES or NO

Kidney problem ----- YES or NO

Pacemaker ----- YES or NO

Prostheses (for example, metal rods, screws or plates) ----- YES or NO

Neurological problem (for example, stroke, ministroke) ----- YES or NO

If yes, describe: _____

Thyroid disease ----- YES or NO

Ulcers ----- YES or NO

Have you ever had any serious injuries that resulted in permanent scars or disability? - YES or NO

If yes, please describe. _____

Please describe other medical illnesses that you have had, which are not mentioned above.

Please list all operations which you have had and the year of your surgery.

Operation	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Name: _____

Obstetric and gynecological history (for women only):

How many times were you pregnant? _____

How many vaginal deliveries? _____

How many Caesarean sections? _____

Have you ever had a rectal laceration? _____

When was your last menstrual period? _____

MEDICATIONS

Do you take any prescription medications? ----- YES or NO

If yes, please list your current medications and dosages.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Please list the non-prescription medications which you take (for example, aspirin or vitamins).

1. _____ 3. _____

2. _____ 4. _____

ALLERGIES AND SENSITIVITIES

Are you allergic to any medications? ----- YES or NO

If yes, please list the medications to which you are allergic and describe the reaction you had to each medication. _____

Are you allergic to iodine, contrast agents, sea food or latex? ----- YES or NO

If yes, to which? _____

Name: _____

FAMILY HISTORY

Has any blood relative ever had cancer of the colon or rectum? ----- YES or NO

If yes, who? _____ At what age? _____

Has any blood relative ever had colon or rectal polyps? ----- YES or NO

If yes, who? _____

Has any blood relative ever had ulcerative colitis or Crohn's disease? ----- YES or NO

If yes, who? _____

Has any blood relative ever had endometrial, stomach, ovarian, kidney/urinary tract, biliary tract,
brain, small bowel or pancreatic cancer? ----- YES or NO

If yes, who and which cancer? _____

SOCIAL HISTORY

Circle one: Are you employed, unemployed, retired or disabled?

What is your occupation? _____

Do you consume alcohol now? ----- YES or NO

If yes, what do you drink, how much and how often? _____

Were you a heavy drinker or alcoholic in the past? ----- YES or NO

Do you now or have you ever smoked? ----- YES or NO

If yes, please circle which. Cigarettes cigars pipe

How many packs of cigarettes per day? _____ For how many years? _____

Do you still smoke? ----- YES or NO

If no, when did you quit? _____

How many cups of coffee do you drink in a day? _____

(Optional) Do you engage in heterosexual activity? ----- YES or NO

(Optional) Do you engage in homosexual activity? ----- YES or NO

Have you traveled outside of the United States in the last 3 years? ----- YES or NO

If yes, where to? _____