

Name: _____

Age: _____ Date of Appointment: _____

Who were you referred by? _____

Who is your primary care physician? _____

Please name your other doctors. _____

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

Check YES or NO and write in answers.

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

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

Where do you see the blood? Check 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 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 NO

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

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

If yes, when is the itching worst? _____

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

Do you have anal discharge, drainage, leakage, or staining? ----- YES NO

If yes, describe. _____

Name: _____

How would you describe your bowel movements?

Check 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** **NO**

If yes, how frequently? _____

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

If yes, how frequently? _____

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

If yes, how frequently? _____

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

If yes, please describe. _____

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

If yes, please describe. _____

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

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

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

If yes, describe. _____

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

If yes, when? _____

If yes, what was found? _____

Have you ever had a barium enema or virtual colonoscopy? ----- **YES** **NO**

If yes, when? _____

If yes, what was found? _____

PAST MEDICAL HISTORY

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

Autoimmune disease ----- **YES** **NO**

Blood transfusions ----- **YES** **NO**

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

If yes, describe: _____

Cancer ----- **YES** **NO**

If yes, what type? _____

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

If yes, for how long? _____

Diabetes ----- **YES** **NO**

If yes, for how long? _____

Gastroesophageal Reflux Disease (GERD) ----- **YES** **NO**

Name: _____

Heart disease ----- **YES** **NO**

If yes, describe and give dates. _____

Hepatitis or jaundice ----- **YES** **NO**

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

Kidney problem ----- **YES** **NO**

Pacemaker ----- **YES** **NO**

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

Neurological problem (for example, stroke, mini stroke) ----- **YES** **NO**

If yes, describe: _____

Thyroid disease ----- **YES** **NO**

Ulcers ----- **YES** **NO**

Do you get chest pain, shortness of breath or heart palpitations? ----- **YES** **NO**

Have you ever had any serious injuries, permanent scars or disability? ----- **YES** **NO**

If yes, please describe. _____

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

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

If yes, when and what was done? _____

Please list all other 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** **NO**

If yes, please list your current medications and dosages.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

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** **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** **NO**

If yes, to which? _____

Name: _____

FAMILY HISTORY

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

If yes, who? _____ At what age? _____

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

If yes, who? _____

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

If yes, who and which cancer? _____

SOCIAL HISTORY

Check one: You are **employed** **unemployed** **retired** **disabled**

What is or was your occupation? _____

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

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

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

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

If yes, please check which. **Cigarettes** **cigars** **pipe**

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

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

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

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

If yes, where to? _____