

Colon and Rectal Clinic

Patient Name: _____ Age: _____ Date of Visit: _____
 Height: _____ Weight: _____ Temp: _____ BP: _____ HR: _____

PREVIOUS ILLNESSES (Please list any illnesses you have had and the dates of the occurrences)

PREVIOUS COLON SCREENING (Please list the most recent colon screenings you have undergone including the procedure dates)

Flexible Sigmoidoscopy _____ Colonoscopy _____
 Barium Enema _____

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrences)

MEDICATION (Please list all medications that you are currently taking including the dose you take. Please include over-the-counter supplements and herbal medications)

ALLERGIES (Please list any medication you are allergic to and explain the reaction to the medication)

No Known Drug Allergies _____

FAMILY HISTORY (Please list your family member and the appropriate disease)

Colon Cancer _____ Other _____
 Rectal Cancer _____
 Polyps _____

REVIEW OF SYSTEMS (Have you had or do you currently have a history of any of the following? Please check all that apply.)

General <input type="checkbox"/> Recurrent fever <input type="checkbox"/> Significant weight change	Cardiovascular <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart attack <input type="checkbox"/> Abnormal heart value	Urologic <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary incontinence	Female Reproductive <input type="checkbox"/> Irregular menstruation <input type="checkbox"/> Vaginal spotting <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Endometriosis	Neurologic Psychiatric <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure <input type="checkbox"/> Fainting or blackouts <input type="checkbox"/> Anxiety <input type="checkbox"/> Phobia <input type="checkbox"/> Depression
Eye, Ear & Throat <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Sinus problems <input type="checkbox"/> Dental problems <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Hoarseness <input type="checkbox"/> Recent sore throat <input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Swollen feet <input type="checkbox"/> Abnormal stress test <input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood thinner use <input type="checkbox"/> High cholesterol Abdominal/GI <input type="checkbox"/> Hernia <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Reflux <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Jaundice	Male Reproduction <input type="checkbox"/> Prostate gland problems <input type="checkbox"/> Abnormal PSA <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Penile discharge <input type="checkbox"/> Testicular pain/mass	Enter number of previous pregnancies: _____ Respiratory <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Productive cough <input type="checkbox"/> With sputum <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing	Personal Habits (circle) Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/>
Hematologic <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Disorder	Dematologic <input type="checkbox"/> Rash <input type="checkbox"/> Skin cancer	Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Hormonal abnormalities <input type="checkbox"/> Steroid use	Rheumatologic <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Arthritis	Other Primary Care Doctor Other Physicians
Oncology <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation				

Encounter Time: _____ mins Counsel Time: _____ mins
 I have reviewed the above information with the patient on this date. All boxes which are not checked are either negative or N/A
 Physician's Signature _____ Date _____