



Colon & Rectal Specialists, Ltd.

NEW PATIENT MEDICAL AND SURGICAL HISTORY

Date: _____

Patient's name: _____ Age _____

Present complaint or illness: _____

PREVIOUS SURGICAL HISTORY

Name of Surgery/Type of Surgery

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____

PREVIOUS SERIOUS ILLNESS OR HOSPITALIZATION

Illness/Hospitalization

Date of Hospitalization

_____	_____
_____	_____
_____	_____

MEDICATIONS

Current Medications

Dosage

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

MEDICAL HISTORY

Diabetes No Yes
Hypertension No Yes
Congestive Heart Failure No Yes
Stroke No Yes
Heart Attack No Yes

FOR FEMALES ONLY:

of Pregnancies _____
of Miscarriages _____
Date of last menstrual period _____

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed
 Use of Alcohol: Never Rarely Moderate Daily
 Use of Tobacco: Never Previously, but quit Current packs/day _____
 Use of Drugs: Never Type/Frequency _____

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____

SYSTEM REVIEW (PLEASE CIRCLE YES OR NO)

CONSTITUTIONAL SYMPTOMS

Good, General Health.....No..... Yes
 Recent Weight Loss.....No..... Yes _____ Lbs.
 Recent Weight Gain.....No..... Yes _____ Lbs.
 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 Thought.....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 or Heartburn No..... Yes
 Rectal Bleeding No..... Yes

GENITOURINARY

Burning or Painful Urination.....No..... Yes
 Difficulty Urinating.....No..... Yes
 Frequent Urinating.....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 _____