



**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

	<b>Age</b>	<b>Diseases</b>	<b>If deceased, cause of death</b>
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 \_\_\_\_\_