Patient Medical History
Proctology

Please list the **current** proctologic problem(s) for which you are here today. When did they begin?

Problems	Date Began

Other Medical Care:

Are you are being treated for any other illness or medical problems by another physician or physical or mental health practitioner? □ YES □ NO

If yes, please describe the problem(s) and write the name of the physician, health practitioner or medical facility treating you. Use back of page if more space is needed.

Illness or Medical Problem	Physician or Medical Facility	City and State

Past Surgeries: □ NO SURGERIES Blood Transfusion(s) □ YES □ NO

List any past surgeries with approximate year: _____

_____

Current Medication	**Strength/Dosage**	**Reason for Taking**

Current Allergies: Please list all known allergies along with type of reaction: _____

_____

Do you use any of the following?(circle) **Eyeglasses Dentures Contact Lenses Hearing Aid Artificial Limb**
Have you ever had any of the following? (circle) **Barium Enema Flexible Sigmoid scope Colon Polyp**
Do you take blood thinners (i.e. daily aspirin, coumadin, etc.) YES NO
Do you require antibiotics when having dental work done? YES NO
Are you on a special diet? YES NO If so, what kind? _____
Have you ever had a colon exam or colonoscopy? YES NO If so, when and where? _____
Have you had an EKG in the last year? YES NO If so, where? _____
Have you had stomach/chest/colon x-ray in the past 2 years? YES NO If so, where? _____

Check any of the following that apply to you:

□ Diabetic □ High Cholesterol □ High Blood Pressure □ Asthma
□ Heart Attack □ COPD/Emphysema □ Have a Pacemaker

Social: (check all boxes that apply)

□ drink coffee/tea ___cups/day □ Smoke Cigarettes ___ packs/day ___years □ Exercise Regularly
□ Alcohol ___drinks/day □ Former Smoker, quit ___years ago □ Use smokeless tobacco

PATIENT MEDICAL HISTORY
PROCTOLOGY

Family History: If any of the following run in your family, check appropriate box(es), and state relationship:

□ Cancer_____ □ Hypertension _____
□ Heart Disease _____ □ Stroke _____
□ Diabetes _____ □ Alcoholism _____
□ Thyroid Disease _____ □ Colon Polyps _____
□ Other _____

Review of Current Symptoms: Circle any symptoms that you are currently experiencing.

1. Head and Neck

Headaches	YES	NO	Ringing in the Ears	YES	NO	Glasses/Contact Lenses	YES	NO
Pain in the Ears	YES	NO	Eye Pain	YES	NO	Discharge from the Ear	YES	NO
Double Vision	YES	NO	Repeat Nosebleeds	YES	NO	See 'Floating Lights'	YES	NO
Frequent Colds	YES	NO	Persistent Neck Rigidity	YES	NO	Severe Hearing Loss	YES	NO
Prolonged Hoarseness	YES	NO	Swelling in Neck	YES	NO			

2. Heart/Cardiovascular

Hypertension	YES	NO	Chest Pain on Effort	YES	NO	Skipping/irregular heartbeat	YES	NO
Difficulty Breathing	YES	NO	Ankles Swell	YES	NO	Heart Problems	YES	NO

If yes to heart problems, please explain: _____

3. Lungs/Pulmonary

Sit up to breathe easier	YES	NO	Spit up Blood	YES	NO	Wheezing	YES	NO
Chronic Cough	YES	NO	Frequent Chest Colds	YES	NO	Have Night Sweats	YES	NO

4. Stomach and Intestines

Chronic abdominal pain	YES	NO	Vomit Blood	YES	NO	Bleeding from Rectum	YES	NO
Persistent Nausea	YES	NO	Skin Turns Yellow	YES	NO	Clay covered stool	YES	NO
Heartburn	YES	NO	Chronic Diarrhea	YES	NO	Habitual Constipation	YES	NO
Appetite Loss	YES	NO	Black Tarry Stool	YES	NO	Hemorrhoids	YES	NO
Bloating	YES	NO	Anal/Rectal Itch	YES	NO	Change in Bowel Habits	YES	NO

5. Urinary Tract, Etc.

Frequent Urination	YES	NO	Pain with Urination	YES	NO	Hard to start Urinary Flow	YES	NO
Leakage of Urine	YES	NO	Scanty Urination	YES	NO	Passed any Stones	YES	NO
Blood in Urine	YES	NO	Bedwetting	YES	NO	Frequent Night Urination	YES	NO
Retention of Urine	YES	NO						

Men:

Prostate Problems YES NO If yes, explain _____

Women (OBGyn):

Currently Pregnant YES NO Last Menstrual Period_____ # of Pregnancies ____ # of Living Children ____

6. Muscles/Joints

Joint/Muscle Problems	YES	NO	Shoulder Pain	YES	NO	Physical Handicap/Limitation	YES	NO
Back Pain	YES	NO	Tingling Sensations	YES	NO	Numbness	YES	NO
Disturbance in walking	YES	NO	Muscle Jerking	YES	NO	Paralysis/Weakness	YES	NO
Shaking	YES	NO	Stroke	YES	NO	Seizures	YES	NO

7. Neuropsychological

Depression	YES	NO	Nervous Breakdown	YES	NO	Mental Problems	YES	NO
Dizzy Spells	YES	NO	Memory Loss	YES	NO	Personality Changes	YES	NO
Speech Disturbances	YES	NO	Alcohol Problems	YES	NO	Psychotherapy/Counseling	YES	NO
Serious Mental Problems	YES	NO	Drug Problems	YES	NO			

I have been provided a copy of the office HIPAA policy to review, and understand a copy is available to me upon request

_____

Signature (Parent or Guardian if Patient is a Minor) Date