Patient Name:_____ **Today's date:**_____

Date of Birth:_____ **Age :**_____ **Current Height:**_____ **Current Weight:**_____

Reason for today's visit: _____

Are you currently experiencing any of the following?

_ Anal itching	__ Bleeding with bowel movements	__ Need for laxatives
_ Anal Pain	__ Change in size of stool	__ Pain with bowel movements
_ Anal Swelling or protrusion	__ Change in stool frequency	__ Trouble controlling stool/gas
_ Anal Drainage	__ Constipation	__ Unintentional weight loss
_ Abdominal Pain	__ Diarrhea	__ Other
_ Abdominal Swelling/Distension	__ Incontinence	

Allergy List:

Allergy	Reaction

Medication List: ***Please list all current medications, including vitamins, supplements and dosages: (Can send separate sheet)***

Name	Dose	Frequency

Family Medical History:

Has anyone in your family had any of the following? (Specify which relative, if any were under age 50, please indicate):

Colorectal cancer:_____

Colon Polyps:_____

Crohn's Disease:_____

Ulcerative Colitis:_____

Ovarian cancer:_____ **Under 50?**_____

Uterine/Endometrial Cancer:_____

PROBLEMS WITH ANESTHESIA:_____

Breast Cancer:_____

Surgical History_____

_____ Colonoscopy / ____ Sigmoidoscopy (Date):_____ **Where:**_____
Findings from above evaluation(s):_____

Social History:

Tobacco: ◯ **Current smoker/daily** ◯ **Current smoker/sometimes** ◯ **Former smoker** ◯ **Never**

Alcohol Use: ◯ **Yes** ◯ **No** ◯ **Social** ◯ **Daily** ◯ **History of Addiction**

Do you have/ need any of the following? ◯ **Glasses** ◯ **Contact Lenses** ◯ **Denture (Upper/ Lower)** ◯ **Capped Teeth** ◯ **Hearing Aid** ◯ **Partial Bridge** ◯ **Assistance Walking**

Any cultural or religious concerns:_____

PLEASE COMPLETE BOTH FRONT AND BACK OF THIS FORM

Patient Name:_____ **Date Of Birth:**_____

Primary or Referring Doctor:_____

Past Medical History: Please check **YES** if you have experienced any of the following conditions/symptoms; otherwise check **NO.**

General	YES	NO	Musculoskeletal	YES	NO
Problems w/ anesthesia (describe)			Arthritis (specify type):		
Antibiotics for dental work			Back pain/injury		
Recent Cold/Flu/Sore throat			Fibromyalgia		
Recent Fever			Lupus		
Recent Hospitalization (list)			Gout		
Recent injury			◯ Osteopenia/◯ Osteoporosis		
Cardiac (Heart Problems)			**Pulmonary (Respiratory)**		
◯ Pacemaker			Asthma		
◯ Defibrillator			Deep Vein Thrombosis		
◯ Stents			Pulmonary Embolism		
◯ Angioplasty			Bronchitis		
Arrhythmia			Emphysema/COPD		
Atrial Fibrillation			Hay fever		
Chest Pain (outcome & diagnosis)			Home oxygen		
Heart attack (MI)			Seasonal allergies		
High Cholesterol			Shortness of breath		
Hypertension (High Blood Pressure)			Sleep Apnea		
Mitral Valve Prolapse			**Kidney/Urinary Problems**		
Palpitations			ESRD/Dialysis (type):		
			Frequent urination		
GI (Intestinal Problems)			Incontinence		
Anal cancer			Kidney stones		
Anal Fissure			Prostate enlargement		
Anal Fistula			Prostate cancer		
Anal Warts (Condyloma)			**Neurological**		
Colon/Rectal Cancer			Migraine headaches		
Colon/Rectal Polyps			Multiple Sclerosis		
Crohn's Disease			Seizure disorder		
Diverticulitis (infection)			Stroke		
Diverticulosis			TIA		
Irritable Bowel Syndrome (IBS)			**Endocrine**		
◯ Reflux / ◯ Peptic Ulcer			Diabetes Mellitus-Type I		
Ulcerative colitis			Diabetes Mellitus-Type II		
			Graves disease		
Psychiatric History			Hyperthyroid (high)		
ADD / ADHD			Hypothyroid (low)		
Anxiety			**Ophthalmology (Eyes)**		
Bipolar Disorder			Cataracts		
Depression			Glaucoma		
Eating disorder			Glasses/contact lenses		
Schizophrenia			**Hematology (Blood)**		
Infection History			Anemia		
Genital Herpes			Bleeding disorder (type):		
Hepatitis – A, B, or C (circle)			**Gynecology (GYN)**		
HIV / AIDS			Endometriosis		
MRSA			Fibroids		
Tuberculosis			**Oncology (Cancer): List:**		

Please add any other medical conditions not listed on this form:_____