New Patient History Form

Name:	Date of Birth:
Referring Physician:	Primary Care Physician:
Any other physician who should receive an update of your records?	

Why are you here today?

Colon and Anorectal History

	Rectal Bleeding	Anal Pain	Rectal Drainage	Anal Mass	Abdominal Pain
Do you have any of the following? (check all that apply)	☐	☐	☐	☐	☐
For how long? (days, weeks, months, years)					
What makes it better and what makes it worse?					
Any other relevant details?	☐ Bright Red ☐ Maroon ☐ On or in stool ☐ In toilet water ☐ on toilet paper	☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning	☐ Pus ☐ Stool ☐ Yellow Fluid ☐ Mucous	☐ Firm ☐ Soft ☐ Growing ☐ Shrinking	☐ Upper ☐ Lower ☐ Right ☐ Left ☐ Middle ☐ Dull ☐ Sharp

	YES	NO		YES	NO
Have you lost weight If yes, how many pounds_____, over how much time_____ Why did you lose weight? ☐ **Pain** ☐ **Dieting** ☐ **Loss of appetite** **Other:**_____ **What is your height:**_____	☐	☐	**Have you had anal surgery** What procedure(s)?_____ Where?_____When?_____ **Do you have a stoma and/or do you need to see a wound care nurse?**	☐	☐
Number of BMs:_____☐ per day or☐ per week Are they: ☐ **Hard** ☐ **Soft** ☐ **Mushy** ☐ **Liquid** Any problems with control of solid stool Any problem with control of liquid stool Any problem with control of gas **Do you take :**☐ **Fiber** ☐ **Laxatives** ☐ **Anti-diarrhea** **What kind of fiber, laxatives or anti-diarrhea medications do you take?**_____ **How often?**_____	☐ ☐ ☐	☐ ☐ ☐	**Have you ever had a colonoscopy** What year_____ Where_____ Did it show anything abnormal? **Have your symptoms changed since your last scope?** Have you ever had colon polyps? Did you have more than 10 polyps	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Do you use medication on your anus? If yes, what kind_____ How often?_____	☐	☐	**Have you ever had a barium enema study?** What year(s)?_____ Where?_____ Did you show anything abnormal?	☐ ☐	☐ ☐
Do you have any close family members that have been diagnosed with colon polyps or colon/rectal cancer? Who and what kind?_____	☐	☐	**Do you smoke cigarettes or vape?** Packs per day_____ Quit when:_____ **Illegal Substances?** What Kind?_____ **Do you drink alcohol?** How often? _____	☐ ☐ ☐	☐ ☐ ☐
Do you have any allergies? What kind? _ex. Latex, medications_____	☐	☐	**Do you take Opioids?** What kind and dosage? _____	☐	☐
Are you married? **Do you have children?** **#Male** __ **#Female** ____	☐ ☐	☐ ☐	**Are your parents living?** Mother Father:	☐ ☐	☐ ☐

Surgical history	Current Medications

Your Medical History

Have you had or are you being treated for any of these problems? (Please check all that apply)

Blood Problems
- ☐ Anemia
- ☐ Blood Clots/ DVT/Embolism
- ☐ Clotting disorder
- ☐ Bleeding disorder
- ☐ HIV Positive
- ☐ Sickle Cell

Cardiac/Vascular
- ☐ Chest pain (angina)
- ☐ Heart attack or arrhythmia
- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Malignant hyperthermia

Cancer – List type/location
- ☐ _____
- ☐ _____
- ☐ _____

Endocrine
- ☐ Diabetes
- ☐ Hyperthyroid disease
- ☐ Hypothyroid disease
- ☐ Adrenal disease

Gastrointestinal
- ☐ Anal/Rectal trauma/injury
- ☐ Colorectal polyps
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Leakage of stool
- ☐ Ulcerative colitis

Infection
- ☐ Hepatitis type:
- ☐ MRSA

Kidney/Urinary
- ☐ Leakage of urine
- ☐ Poor kidney function
- ☐ Renal failure

Musculoskeletal
- ☐ Arthritis
- ☐ Back problems
- ☐ Gout
- ☐ Pelvic fracture

Neurological
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Seizures
- ☐ Spinal cord injury
- ☐ Stroke
- ☐ TIA

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other _____

Are you experiencing any of these symptoms? *Please check all that apply*

Constitutional

Fever	☐ Yes ☐ No
Chills	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No

Allery/Immunology

Congestion	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Sneezing	☐ Yes ☐ No

Ophthalmologic

Blurred vision	☐ Yes ☐ No

Endocrine

Heat or Cold intolerance	☐ Yes ☐ No
Excessive sweating	☐ Yes ☐ No
Excessive thirst	☐ Yes ☐ No

Cardiovascular

Chest pain	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No
Chest pain with exertion	☐ Yes ☐ No
Irregular heartbeat	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No

Gastrointestinal

Dark tarry stools	☐ Yes ☐ No
Blood in stool	☐ Yes ☐ No
Change in bowel habits	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Decreased appetite	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No

Hematologic

AIDS/HIV	☐ Yes ☐ No
Excessive bleeding	☐ Yes ☐ No

Genitourinary

Difficulty urinating	☐ Yes ☐ No

Neurologic

Balance difficulty	☐ Yes ☐ No
Coordination trouble	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No

Colorectal

Loss of bowel/bladder control	☐ Yes ☐ No
Accidental loss/ leakage of stool	☐ Yes ☐ No
Accidents-with passing gas or sleeping	☐ Yes ☐ No
Frequent, loose, watery stool	☐ Yes ☐ No
Sudden or strong urge to go to the bathroom	☐ Yes ☐ No