COLON AND RECTAL SURGERY ASSOCIATES
HISTORY AND PHYSICAL

Name_____ **Age**_____ **Sex: M F**

Reason for visit: _____ **HT:** _____ **WT:** _____

Referred by: _____ **Primary is Dr.** _____

I also see Dr. _____ **Dr.** _____

Occupation: _____ **Place of employment:** _____

Medications: (separate list if necessary)

1)_____**mg**_____**times/day** **4)**_____**mg**_____**times/day**
2)_____**mg**_____**times/day** **5)**_____**mg**_____**times/day**
3)_____**mg**_____**times/day** **6)**_____**mg**_____**times/day**

Medication Allergies & Reaction:_____

_____

Colon exam: Last colonoscopy:(year)_____ performed by _____Barium enema: (year)_____

If having colonoscopy specify type: Screening (preventive)_____Diagnostic (previous polyps, etc.) _____

Family History: (blood relation): **Colon Cancer** _____ **Colon Polyps** _____

Breast Cancer: _____**Uterine or Ovarian Cancer:** _____ **Other serious ailments:**_____

Past Surgeries: (with approx. date) _____ _____

_____ _____ _____

_____ _____ _____

Social history: At home I live….alone / with _____

Tobacco: No__ Yes ___/ ____ packs per day. **Alcohol:** No___ Yes ___/ _____drinks/beers per day.

(Check all that apply)

REVIEW OF SYSTEMS:

Gastrointestinal
5 Bleeding with BMs
5 Constipation
5 Change in bowel habits
5 Diarrhea
5 Rectal pain
5 Soiling/ Incontinence
5 Heartburn
5 Abdominal pain
5 _____

Skin
5 Bruise easily
5 Rashes

Endocrine
5 Diabetes
5 Hypo/hyperthyroid
5 Steroid use

General
5 Fevers
5 Chills
5 Sweats
5 Weight loss
5 Bleeding history
5 Immune Deficiency

Urinary
5 Painful Urination
5 Blood in Urine
5 Air in Urine
5 Recurrent Infections
5 Incontinence
5 Dialysis

Muscle/Joint
5 Arthritis
5 Weakness in _____

Respiratory
5 Asthma
5 Bronchitis
5 Shortness of breath
5 Productive cough

Cardiovascular
5 High Blood Pressure
5 Heart Attack
5 Irregular Heart Beat
5 Rapid Heart Beat
5 Mitral Valve Prolapse
5 Valve Disease
5 Leg Swelling

Neurological
5 Permanent stroke
5 Transient stroke
5 Seizures

Cancer Treatment
5 Chemo **5** Radiation (area treated & year)
_____
_____

Blood Disorders:
5 HIV/AIDS

Reproductive
(men only)
5 Erectile dysfunction

(women only)
5 Hysterectomy
5 Childbirth
children _____
5 Difficult delivery (tearing)
5 C-section: #_____
5 Still Menstruating

Other Medical Problems: _____

_____

_____ _____
PATIENT'S SIGNATURE **DATE**_____

DATE: _____ _____
Physician Signature

Reviewed with patient and agree with above:
☐ J. GRIFFIN, MD ☐ S. MAYFIELD, MD
☐ H. McCARTHY, MD ☐ J. SILINSKY, MD
☐ M. ZELHART, MD