

Patient Name: _____

Date of Birth: _____

(Please answer all questions to the best of your ability and ask the staff if you have any questions or concerns. Circle either Yes or No or circle the word that best describes your answer.)

- Do you have any rectal pain?.....Yes / No
- Do you have any abdominal pain?.....Yes / No
- Do you have any rectal bleeding?.....Yes / No
- What is the color of the bleeding?..... (Bright red/Dark red/Maroon/Black)
- How many bowel movements do you have in a day?..... _____
- What are your bowel movements like?.....(Loose/Soft/Hard)
- What is diameter of stool?..... (1inch, 1 ½ inches, 2 inches, or 3 inches)
- How long do you sit to move your bowels?..... (5 minutes/10 minutes/1/2 hour/1 hour)
- Do you have any problems with diarrhea or constipation?.....Yes / No
- Do you have any swelling around the rectum?.....Yes / No
- Have you noticed any lumps or bumps near or coming out of your rectum?.....Yes / No
- Do you have any discharge from you rectum (Ex: mucous or pus)?.....Yes / No
- Do you ever have to hurry to the bathroom to avoid an accident?.....Yes / No
- Do you have any leakage of stool?.....Yes / No
- Do you ever leak any urine?.....Yes / No
- Do you use any of these medications to have bowel movements?.....(Miralax/Ex-lax/Milk of Magnesia/Dulcolax/Enemas/Suppositories)
- Do you have any family history of Colon or Rectal Cancer?.....Yes / No
- Have you had a colonoscopy? If so when and where was it done? _____

Comments: _____

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Past hospitalizations, surgeries, injuries: _____ Date _____

Any complications after surgery? _____

Complications from anesthesia or sedation? _____

Present conditions requiring medical care: Condition/How long?	Doctor	Last Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Occupation: _____ Religion: _____

Do you or have you ever smoked? Yes No How long? _____

Number of packs daily: _____ When did you quit? _____

Do you or have you ever drunk alcohol? Yes No Type of alcohol: _____

How often? _____ How much? _____

Do you or have you ever used street drugs? Yes No What type/how often? _____

Exercise Routine/Type: _____ How often: _____

Marital status: Single Married Separated Divorced Widowed

Number of children: _____ Do you live alone? _____ Do you drive a car? _____

Significant Family History - List family members (parents, grandparents, brothers/sisters, children) who have had any of the following conditions:

Heart disease _____	Stroke _____
High Blood Pressure _____	Diabetes _____
Thyroid _____	Lung Disease _____
Cancer _____	Bleeding Disorder _____
Liver Disease _____	Gallbladder _____

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Check the conditions you have had in the past, or currently have.

- | | | | |
|---------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> colon polyps | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> colitis | <input type="checkbox"/> broken bones |
| <input type="checkbox"/> unintended weight loss | <input type="checkbox"/> anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> gout |
| <input type="checkbox"/> anorexia/bulimia/
eating disorder | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> diverticulosis (pockets in colon) | <input type="checkbox"/> artificial joints |
| <input type="checkbox"/> skin condition | <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> chemical dependency |
| <input type="checkbox"/> skin cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> frequent diarrhea | <input type="checkbox"/> nervousness/phobia |
| <input type="checkbox"/> skin rash | <input type="checkbox"/> leg swelling | <input type="checkbox"/> constipation | <input type="checkbox"/> depression/anxiety |
| <input type="checkbox"/> change in mole | <input type="checkbox"/> clot in leg/phlebitis | <input type="checkbox"/> black/bloody stools | <input type="checkbox"/> physical/sexual abuse |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> heart attack/MI | <input type="checkbox"/> leaking stool | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> frequent strep throat | <input type="checkbox"/> rheumatic fever | # of BM's daily _____ | <input type="checkbox"/> balance problems |
| <input type="checkbox"/> voice changes | <input type="checkbox"/> previous stroke/TIA | <input type="checkbox"/> rectal pain | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> varicose veins | <input type="checkbox"/> swelling at rectum | <input type="checkbox"/> weakness |
| <input type="checkbox"/> dizzy/fainting spells | <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> rectal protrusion | <input type="checkbox"/> seizures |
| <input type="checkbox"/> hearing changes | <input type="checkbox"/> heart murmur | <input type="checkbox"/> urine infections | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> artificial heart valve/stent | <input type="checkbox"/> frequent urination | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> wheezing/asthma | <input type="checkbox"/> leg cramps when walking | <input type="checkbox"/> prostate problems | <input type="checkbox"/> thyroid condition |
| <input type="checkbox"/> emphysema/COPD | <input type="checkbox"/> leg ulcers | <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> change in phlegm/sputum | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> urine leakage | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> blood in urine | <input type="checkbox"/> blood transfusions |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> decreased appetite | <input type="checkbox"/> kidney stones | <input type="checkbox"/> cancer |
| <input type="checkbox"/> bronchitis/pneumonia | <input type="checkbox"/> stomach ulcer | <input type="checkbox"/> sexual preference | |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> hernia | _____ | |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> sexually transmitted disease | |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> heartburn/reflux/indigestion | <input type="checkbox"/> menstrual irregularity | |
| | <input type="checkbox"/> jaundice | <input type="checkbox"/> menstrual pain/cramps | |
| | <input type="checkbox"/> hepatitis A B C | <input type="checkbox"/> post-menopausal | |
| | <input type="checkbox"/> gallbladder trouble | <input type="checkbox"/> vaginal tear at delivery | |

Notes: _____

Women Only

Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
Birth Control Method: _____ Last Menstrual period: _____
Date of last pap test and result: _____
Date of last mammogram and result: _____

Pediatric Patients Only (ages birth to 16 years)

Birth by: Vaginal delivery C-Section Any complications? Yes No
Born prematurely? Yes No If yes, how many weeks? _____
Vaccinations up to date? Yes No

The above information is true and correct to the best of my knowledge.

Patient's Signature: _____
Staff Signature: _____ **Date:** _____

Patient Name: _____

Date of Birth: _____

Physical Exam

Age _____ Height _____ Weight _____ Temp _____ Pulse _____ RR _____ BP _____

General: alert no distress _____

Skin: warm dry no lesion _____

HEENT: hearing & vision intact PER EOMI sclerae white pharynx clear
 mucosa moist _____

Neck: supple nl thyroid no nodes no JVD no bruit _____

Lungs: equal BS no rales no rhonchi no wheeze _____

Heart: RRR no murmur S1&S2 _____

Breast: no nipple retraction no dimpling no mass no discharge no adenopathy no skin changes

Abdomen: scaphoid BS+ nontender soft no mass no HSM no hernia
 no pulsation no bruit

Back: nontender _____

GU: nontender no testicular mass no hernia no discharge

Extremities: ambulatory nl ROM no edema no ulcers no clubbing no cyanosis
 nl CPR _____

Circulation:	radial	brachial	carotid	Femoral	popliteal	post tib	dors ped
Left							
Right							

Rectal: nl tone no mass nl prostate guaiac neg
Anoscopy _____ Proctoscopy _____ Flex. Sig. _____

Neuro: orientedx3 CN2-12 intact no gross deficit

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Labs:

X-Rays:

Impression:

Plan:

Entire form, including ROS, for today's exam has been reviewed by provider? Yes No

Patient is being seen in consultation at the request of _____
for _____. A letter is being sent to the
requesting physician.

Provider Signature: _____ Date: _____