



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)
- 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)

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

| Past hospitalizations, surgeries, injuries: | Date  |
|---|-------|
| _____                                       | _____ |
| _____                                       | _____ |
| _____                                       | _____ |
| _____                                       | _____ |
| _____                                       | _____ |
| _____                                       | _____ |

Any complications after surgery? \_\_\_\_\_

Complications from anesthesia or sedation? \_\_\_\_\_

| Present conditions requiring medical care:<br>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/<br>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"/> sexually transmitted disease      |  |
| <input type="checkbox"/> tuberculosis                         | <input type="checkbox"/> abdominal pain               | <input type="checkbox"/> menstrual irregularity            |  |
| <input type="checkbox"/> sleep apnea                          | <input type="checkbox"/> heartburn/reflux/indigestion | <input type="checkbox"/> menstrual pain/cramps             |  |
|   | <input type="checkbox"/> jaundice                     | <input type="checkbox"/> post-menopausal                   |  |
|   | <input type="checkbox"/> hepatitis A B C              | <input type="checkbox"/> vaginal tear at delivery          |  |
|   | <input type="checkbox"/> gallbladder trouble          |  |  |

**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: \_\_\_\_\_