Colon and Rectal Surgery

Name: _____ Date: _____ MRN:_____
Age: _____ Date of Birth: ____-____-_____ Sex: M/F Last Seen _____
Primary Care Physician: _____ Physician who referred you to us: _____

In the interest of your health and well-being, we would like to ask you several questions. Although some questions may seem unnecessary at first, we ask that you answer all of the following to the best of your ability. This information will assist your physician in providing you the best of care.

Current Issue

1. Please describe in a few words the reason for your visit with our physicians.

_____

2. If appropriate, please share with us what you would like to accomplish in seeking care.

_____

3. What have you or your physician done regarding this matter so far?

_____

4. If applicable, has anything improved, worsened or changed?

_____

5. Have you had any special tests, Xrays/imaging, or labs, and if so, what were the results?

_____

Brief Review

1. Are you / Have you ever experienced:			When/Where?	How often?	Description
Pain	Yes	No	_____	_____	_____
Bleeding	Yes	No	_____	_____	_____
Lumps/Bumps/Mass	Yes	No	_____	_____	_____
Anything falling/popping out	Yes	No	_____	_____	_____

2. How often do you have a bowel movement (passage of stool)? _____

3. Please circle all the following that apply to your stool/bowel movements.

Hard	Diarrhea	Runny	Clumpy	Brown	Small Pellets	Painful
Soft	Constipation	Formed	Clay like	Black	Foul Smelling	Straining
Easy	Difficult to Pass	Large	Sticky	Bloody	Very Watery	Stringy

Other _____

4. Do you have any difficulty holding your stool (e.g. incontinence, leakage, urgency)? Yes No
   If yes, please describe. _____

5. Do you have any difficulty in passing stool (e.g. constipation, straining, pain)? Yes No
   If yes, please describe and include any measures you use to assist in the passage of stool.

   _____

   Please list any medications you use to assist with your bowel movements (e.g. softeners, laxatives, enemas)

   _____

6. Do you take a fiber supplement daily (e.g Metamucil)? Yes No

7. Please list any prior colonoscopy you have had. ☐ No Prior Colonoscopy

When	Doctor	Reason	What Hospital or Center	What Was Found

We value your Trust and Confidence in us. We understand many of the conditions we encounter are of a very sensitive nature. If there are any hesitations, concerns, or fears you have in seeking care, please feel free to share them with us, either below or verbally with your physician.

_____

Surgical History

1. Please list any surgical procedures you have had, starting with surgery of your abdomen (Please include minor in office or out-patient procedures such as such as hemorrhoid treatments, skin biopsies, removal of tags).

Surgery	Date	Surgeon	What Hospital?	Reason

Other _____

2. Have you had any problems with excessive or unexpected bleeding after surgical procedures? Yes No
If yes, please describe. _____

3. Have you had any other experiences with surgery we should know about (e.g. problems with anesthesia, problems with excessive pain, etc.)? Yes No
If yes, please describe. _____

Birth/Gestational History (For Females only)

1. G-Number of Pregnancies _____ P-Number of Live Births _____ A-Number of Miscarriages/Abortions _____
L-Current Living Children _____ Birth Weights and Ages at Birth in Weeks _____
2 Number of Vaginal Deliveries _____ Number of Caesarian Sections _____
3. Have you had any tears during childbirth? Yes No Any repairs? Yes No
4. Last Menstrual Period _____ Last Mammogram _____

Family History

1. Has anyone in your family had colon cancer? Yes No
If yes, who, at what age, and what happened? _____

2. Has anyone in your family had polyps of the colon or rectum? Yes No
If yes, who and at what age? _____

3. Has anyone in your family had any other cancers including breast, uterine, ovarian, prostate, stomach, skin, etc.?
Yes/No If yes, who, at what age, and what happened? _____

4. Has anyone in your family had Inflammatory Bowel Disease such as Crohn's Disease or Ulcerative Colitis?
Yes/No If yes, who?_____