Name: _____

Age: _____ **Date of Appointment:** _____

Who were you referred by? _____

Who is your primary care physician? _____

Please name your other doctors. _____

What is your main complaint and reason for your visit? _____

_____

_____

Check YES or NO and write in answers.

Do you have anal or rectal bleeding? ---------- ☐ **YES** ☐ **NO**

If yes, please check the color. ☐ **Bright red** ☐ **Maroon or wine** ☐ **Black like tar**

Where do you see the blood? Check one or more:

☐ **On the tissue** ☐ **In the toilet water** ☐ **On the surface of the stool** ☐ **Mixed in the stool**

How frequently do you see the blood? _____

When did this anal or rectal bleeding start? _____

When was the last time you had anal or rectal bleeding?_____

Do you have anal or rectal pain? ---------- ☐ **YES** ☐ **NO**

If yes, when did you first experience this pain? _____

Please describe the pain. _____

Does something protrude, bulge or stick out from the anus? ---------- ☐ **YES** ☐ **NO**

If yes, can you or do you push the protrusion back in? _____

Do you have anal itching? ---------- ☐ **YES** ☐ **NO**

If yes, when is the itching worst? _____

Do you scratch a lot? ---------- ☐ **YES** ☐ **NO**

Do you have anal discharge, drainage, leakage, or staining? ---------- ☐ **YES** ☐ **NO**

If yes, describe. _____

Name: _____

How would you describe your bowel movements?

Check one or more: ☐ **Watery** ☐ **Loose** ☐ **Fragmented** ☐ **Soft** ☐ **Hard**

How often do you move your bowels? _____

Do you have accidental bowel leakage of gas (flatus)? ---------- ☐ **YES** ☐ **NO**

If yes, how frequently? _____

Do you have accidental bowel leakage of liquid stool? ---------- ☐ **YES** ☐ **NO**

If yes, how frequently? _____

Do you have accidental bowel leakage of solid stool? ---------- ☐ **YES** ☐ **NO**

If yes, how frequently? _____

Do you get abdominal pain? ---------- ☐ **YES** ☐ **NO**

If yes, please describe. _____

Have your bowel habits changed recently? ---------- ☐ **YES** ☐ **NO**

If yes, please describe. _____

Have your stools become narrow? ---------- ☐ **YES** ☐ **NO**

Has your appetite diminished? ---------- ☐ **YES** ☐ **NO**

Have you lost weight? ---------- ☐ **YES** ☐ **NO**

If yes, how many pounds? _____ **Over how many months?** _____

Was this intentional? _____

Have you tried any medicines, diet supplements, laxatives, creams or suppositories to alleviate your symptoms? ---------- ☐ **YES** ☐ **NO**

If yes, describe. _____

Are you currently using any of these remedies? ---------- ☐ **YES** ☐ **NO**

If yes, which ones? _____

Are these remedies helping? _____

Name: _____

Have you ever had a sigmoidoscopy (an examination of your lower colon and rectum by means of a lighted tubular instrument)? ---------- ☐ **YES** ☐ **NO**

If yes, when? _____

If yes, what was found? _____

Have you ever had a colonoscopy (an examination of your entire colon by means of a lighted tubular instrument)? ---------- ☐ **YES** ☐ **NO**

If yes, when? _____

If yes, what was found? _____

Have you ever had a barium enema or virtual colonoscopy? ---------- ☐ **YES** ☐ **NO**

If yes, when? _____

If yes, what was found? _____

PAST MEDICAL HISTORY

Please check YES or NO depending on whether or not you have had the condition.

Autoimmune disease ---------- ☐ **YES** ☐ **NO**

Blood transfusions ---------- ☐ **YES** ☐ **NO**

Bleeding disorder (for example, hemophilia) ---------- ☐ **YES** ☐ **NO**

If yes, describe: _____

Cancer ---------- ☐ **YES** ☐ **NO**

If yes, what type? _____

Chronic lung disease (asthma, emphysema, or bronchitis) ---------- ☐ **YES** ☐ **NO**

If yes, for how long? _____

Diabetes ---------- ☐ **YES** ☐ **NO**

If yes, for how long? _____

Gastroesophageal Reflux Disease (GERD) ---------- ☐ **YES** ☐ **NO**

Name: _____

Heart disease ---------- ☐ **YES** ☐ **NO**

If yes, describe and give dates. _____

Hepatitis or jaundice ---------- ☐ **YES** ☐ **NO**

Hypertension (high blood pressure) ---------- ☐ **YES** ☐ **NO**

Kidney problem ---------- ☐ **YES** ☐ **NO**

Pacemaker ---------- ☐ **YES** ☐ **NO**

Prostheses (for example, metal rods, screws or plates) ---------- ☐ **YES** ☐ **NO**

Neurological problem (for example, stroke, mini stroke) ---------- ☐ **YES** ☐ **NO**

If yes, describe: _____

Thyroid disease ---------- ☐ **YES** ☐ **NO**

Ulcers ---------- ☐ **YES** ☐ **NO**

Do you get chest pain, shortness of breath or heart palpitations? ---------- ☐ **YES** ☐ **NO**

Have you ever had any serious injuries, permanent scars or disability? --------- ☐ **YES** ☐ **NO**

If yes, please describe. _____

Please describe other medical illnesses that you have had, which are not mentioned above.

_____

_____

Have you ever had any operations on the colon or rectum? ---------- ☐ **YES** ☐ **NO**

If yes, when and what was done? _____

Please list all other operations which you have had and the year of your surgery.

Operation	**Year**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Name: _____

Obstetric and gynecological history (for women only):

How many times were you pregnant? _____

How many vaginal deliveries? _____

How many Caesarean sections? _____

Have you ever had a rectal laceration? _____

When was your last menstrual period? _____

MEDICATIONS

Do you take any prescription medications? ---------- ☐ **YES** ☐ **NO**

If yes, please list your current medications and dosages.

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

Please list the non-prescription medications which you take (for example, aspirin or vitamins).

1. _____ **3.** _____

2. _____ **4.** _____

ALLERGIES AND SENSITIVITIES

Are you allergic to any medications? ---------- ☐ **YES** ☐ **NO**

If yes, please list the medications to which you are allergic and describe the reaction you had to each medication. _____

_____

Are you allergic to iodine, contrast agents, sea food or latex? ---------- ☐ **YES** ☐ **NO**

If yes, to which? _____

Name: _____

FAMILY HISTORY

Has any blood relative ever had cancer of the colon or rectum? ---------- ☐ YES ☐ NO

If yes, who? _____ **At what age?** _____

Has any blood relative ever had colon or rectal polyps? ---------- ☐ YES ☐ NO

If yes, who? _____

Has any blood relative ever had ulcerative colitis or Crohn's disease? ---------- ☐ YES ☐ NO

If yes, who? _____

Has any blood relative ever had endometrial, stomach, ovarian, kidney/urinary tract, biliary tract, brain, small bowel or pancreatic cancer? ---------- ☐ YES ☐ NO

If yes, who and which cancer? _____

SOCIAL HISTORY

Check one: You are ☐ employed ☐ unemployed ☐ retired ☐ disabled

What is or was your occupation? _____

Do you consume alcohol now? ---------- ☐ YES ☐ NO

If yes, what do you drink, how much and how often? _____

Were you a heavy drinker or alcoholic in the past? ---------- ☐ YES ☐ NO

Do you now or have you ever smoked? ---------- ☐ YES ☐ NO

If yes, please check which. ☐ Cigarettes ☐ cigars ☐ pipe

How many packs of cigarettes per day? _____ **For how many years?** _____

Do you still smoke? ---------- ☐ YES ☐ NO

If no, when did you quit? _____

How many cups of coffee do you drink in a day? _____

(Optional) Do you engage in heterosexual activity? ---------- ☐ YES ☐ NO

(Optional) Do you engage in homosexual activity? ---------- ☐ YES ☐ NO

Have you traveled outside of the United States in the last 3 years? ---------- ☐ YES ☐ NO

If yes, where to? _____