OVERLAKE MEDICAL CLINICS
COLON AND RECTAL CLINIC

Patient Medical History

Patient's name: _____ **Date:** _____ **Age:**_____
Occupation:_____ **Referring Provider:**_____

Problem or Reason for Office Visit: _____
(Please check any boxes that apply)
☐ **Screening** for colorectal polyps and cancer
☐ **Pain** in the abdomen? _____ in the anus or rectum? _____
When did this first occur? _____
When do you experience this? _____
What makes it worse or better? _____
☐ **Bleeding** from the rectum?
When was the first time you noticed this? _____
How often do you notice bleeding? _____
Is the blood **bright red?** **Dark red?** **Clots?**
Does this occur only with bowel movements? At other times?
☐ **Itching** around the anus?
How severe? _____ How often? _____
☐ **Protrusion or something sticking out** of the anus?
☐ **Seepage or staining** of your underclothes?
Is there trouble controlling your bowel movements?

How often do you *normally* have a bowel movement?
Times per day _____ *or* every how many days? _____
Usual consistency of your bowel movements? Hard Normal Loose
Has there been any significant change in your bowel habits in the last 2 years?
If so how have they changed? _____

Current medications (include aspirin, insulin, inhalers, eye drops, vitamins or supplements); attach an additional sheet if necessary)

	Medication	Dose	How often?		Medication	Dose	How often?
1.	_____	_____	_____	5.	_____	_____	_____
2.	_____	_____	_____	6.	_____	_____	_____
3.	_____	_____	_____	7.	_____	_____	_____
4.	_____	_____	_____	8.	_____	_____	_____

Do you use fiber supplements? _____ **What Type?**_____

Allergies (to medications, anesthetics, topical agents); Check here if **no allergies**: ☐
1. _____ Reaction:_____ 2. _____ Reaction:_____
3. _____ Reaction:_____ 4. _____ Reaction:_____

Surgeries (list type of surgery and approximate year):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Medical History (please check if you have, or have had, any of the following):

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Abnormal heart rhythm
- ☐ Other heart disease
  Specify: _____
- ☐ Asthma as an adult
- ☐ Emphysema
- ☐ Diabetes
- ☐ Stroke
- ☐ Blood clots
- ☐ Cancer (year) _____
  Type/location: _____
- ☐ Anemia
- ☐ Liver failure
- ☐ Kidney failure
- ☐ Reflux/Heartburn
- ☐ Ulcer disease
- ☐ Hepatitis
- ☐ HIV or AIDS
- ☐ Other medical conditions:
  _____
  _____
  _____

Smoking: Current ☐ Former ☐ None ☐ Packs per day ____; Years ____
Alcohol use: Current ☐ Former ☐ None ☐ Drinks per week ____; Years ____
Recreational/medical use of marijuana: Current ☐ Former ☐ None ☐

Have you ever had colon cancer screening? Yes (circle below) No
Colonoscopy Sigmoidoscopy Barium Enema Stool Test for Hidden Blood
Date/findings: _____ Where performed?_____

Family history of any of these (and state who):

- ☐ Colorectal cancer: _____
- ☐ Colorectal polyps: _____
- ☐ Ulcerative colitis/Crohn's disease:_____
- ☐ Other colon diseases: _____

Symptoms Review

(Check beside symptoms you experience; if not checked, it is assumed you do not have that symptom):

Constitutional:
- ☐ Chills
- ☐ Fever
- ☐ Malaise (feel unwell)
- ☐ Weight loss

Head and Neck:
- ☐ Double vision
- ☐ Ear infections
- ☐ Eye pain
- ☐ Nasal congestion
- ☐ Sinus infections
- ☐ Sore throat

Metabolic/Endocrine:
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance

Respiratory:
- ☐ Shortness of breath
- ☐ Frequent cough
- ☐ Pain with deep breath
- ☐ Wheezing

Cardiac:
- ☐ Chest pain
- ☐ Swelling in legs (edema)
- ☐ Palpitations

Skin:
- ☐ Contact allergy
- ☐ Hives
- ☐ Pruritus (itching)
- ☐ Rash

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Loss of appetite
- ☐ Black-colored stools
- ☐ Nausea
- ☐ Reflux (heartburn)
- ☐ Vomiting

Genitourinary:
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

Neurologic:
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐Tremors
- ☐ Spinning sensation

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Increased stress
- ☐ Prev. psychiatric care

Musculoskeletal:
- ☐ Back pain
- ☐ Myalgia (muscle pains)
- ☐ Joint pain

Blood/Lymphatic:
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes

Immunologic:
- ☐ Asthma
- ☐ Food allergies
- ☐ Immunosuppression
- ☐ Seasonal allergies

Reproductive (female):
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Vaginal discharge

Patient signature: _____ Physician signature _____

Date: _____ Date: _____