Patient Medical History

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often?</th>
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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: ________________________

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?  _____________________________
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: ________________

- Cancer (year) __________
- Type/location: __________

- Reflux/Heartburn
- Stroke
- Blood clots
- Ulcer disease
- Hepatitis
- HIV or AIDS
- Other medical conditions:
Specify: ___________________

- Asthma as an adult
- Emphysema
- Anemia
- Liver failure
- Kidney failure

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

(Handwritten list of symptoms, with checkboxes)

Patient signature: ___________________________ Physician signature ___________________________

Date: ___________________________ Date: ___________________________