PATIENT MEDICAL HISTORY

MRN: _____

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Reason for visit: _____

_____

Who referred you to this office? Name: _____ Phone: _____

Address: _____

Who is your Primary Care Physician? Name: _____ Phone: _____

Address: _____

Please list all your medications and their dosages, including over-the-counter medications and vitamins you take regularly.

1.	4.
2.	5.
3.	6.

List any surgery you have had, what type and when, in order of the more recent.

1.	3.
2.	4.

Do you have now?	**Y**	**N**	**Have you ever had?**	**Y**	**N**	**Please fill in (if n/a, leave blank)**
Anemia	☐	☐	Cancer	☐	☐	First day of the most recent menstrual period:
AIDS/HIV	☐	☐	Bleeding Tendency	☐	☐	_____
Diabetes	☐	☐	Transfusion(s)	☐	☐	Age of the first period:_____
Seizures	☐	☐	Heart Attack	☐	☐	Age of menopause: _____
Glaucoma	☐	☐	TB	☐	☐	Total number of pregnancies: _____
High Blood Pressure	☐	☐	Hepatitis/Liver Disease	☐	☐	Total number of live births: _____
Heart Murmur	☐	☐	Radiation Therapy	☐	☐	Age of first full term pregnancy: _____
Asthma	☐	☐		☐	☐	Date of last mammogram: _____
Emphysema	☐	☐		☐	☐	Date of last colonoscopy: _____
Kidney Disease	☐	☐		☐	☐	
Other Active Disease:	_____					

Family history of cancer? Yes ☐ No ☐ If yes, which cancer? _____

History of heart disease? Yes ☐ No ☐ If yes, what type? _____

Do you have a pace maker or stents? Yes ☐ No ☐ If you've quit smoking, when did you quit? _____

Do you smoke or have ever smoked? Yes ☐ No ☐ If yes, packs per day _____ how many years? _____

Do you use alcohol? Yes ☐ No ☐ Drinks/day _____ week _____ month _____

Are you allergic to or had severe reactions to any medications? Yes ☐ No ☐

If yes, which medication(s) _____ and what type of reaction?_____

Do you take aspirin or anti-inflammatories (e.g. Motrin, Aleve)? Yes ☐ No ☐ If yes, which one(s)? _____

Do you take Plavix or any other blood thinner/platelet inhibitor? Yes ☐ No ☐ If yes, which one? _____

Do you take any diet medications? Yes ☐ No ☐ _____

DEPARTMENT OF SURGERY
DIVISION OF COLON & RECTAL SURGERY

Dear Patient:

Please carefully read this consent form and then sign.

Depending on the problem which you have, your surgeon will take a history and perform a physical examination to determine the causes of your complaint and advise you on the possible remedies.

The physical examination *may* include an examination of the external portion of the anus, internal portion of the anus with anoscope and, if appropriate, a procto-sigmoidoscope. A proctosigmoidoscopy is generally performed to determine the source of anal, rectal or colonic bleeding. A proctosigmoidoscopy may not determine the source of bleeding and carries an approximate risk of 1 in 1,000 risk of perforation of the colon. An abnormality found at the time of the proctosigmoidoscopy may be biopsied in the office. This carries an additional risk of bleeding and perforation. Other procedures which may be performed in the office include the removal of thrombosed hemorrhoids, drainage of a rectal abscess and treatment of perianal lesion. These surgical procedures carry a small risk of postoperative bleeding, infection and reaction to the local anesthesia.

Before any therapeutic procedure is performed the doctor will thoroughly discuss with you your options and obtain your verbal consent prior to performing the procedure.

If you have any questions about this consent form or the procedure outlined, please feel free to discuss them with your doctor at the time of your consultation.

I have read the above and consent to examination and treatment by Dr. _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Physician Signature Date

Division of Colon and Rectal Surgery

The GW Medical Faculty Associates

REVIEW OF SYSTEMS:

Please circle any symptoms you currently have

Constitutional: None | Fever | Chills | Weight Loss | Loss of Appetite | Night Sweats | Fainting Spells
Excessive Thirst | Excessive Sweating | Heat Intolerance | Cold Intolerance

Head and Neck: None | Headache | Vision Changes | Runny Nose/Cold | Sinus Problems | Sore Throat | Mouth lesions/ulcers | Ear ache/infection | Hearing Changes | Neck Stiffness/Pain | Enlarged glands/Masses

Cardiovascular: None | Chest Pain | Palpitations | High Blood Pressure

Respiratory: None | Shortness of Breath | Cough | Wheezing | Asthma | Bronchitis | Pneumonia
Smoking – Packs per day: ¼ ½ 1 1½ 2 3 4 For how many years? _____

Gastrointestinal: None | Nausea | Vomiting | Diarrhea | Constipation | Heartburn | Vomited Blood | Anorectal Bleeding | Change in bowel habits | Bowel function: Loss of Control Urgency Frequency BMs per day? _____

Hematologic: None | Easy bruising | Excessive/prolonged bleeding when shaving/brushing teeth
Blood clots | Use/need blood thinners: Aspirin, Coumadin, and Persantine

Urinary: None | Kidney stones | Painful urinating | Difficulty urinating | Leaking urine | Infection

Musculoskeletal: None | Bone pain | Joint pain/Arthritis | Fractures | Back Pain | Neck Pain | Leg pain with walking

Skin: None | Rash | Abscess/Boil | Itching | Eczema | Psoriasis | Other

Neurologic: None | Headaches | Migraines | Dizziness | Weakness/paralysis | Seizures | Stroke

Psychiatric: None | Depression | Hear voices | Fears/phobias | Panic attacks | Other _____

Other symptoms: _____

Reviewed with Patient: _____