COLON & RECTAL SURGICAL ASSOCIATES OF BIRMINGHAM, P.C.

Name:______________________________ DOB:__________________

PAST MEDICAL HISTORY:

Do **YOU** have any or have you ever had any of the following conditions? (Please check all that apply.)

Colon or Rectal Cancer	Heart Disease
Colon Polyps	Blood Clots (where)
Diverticulosis/Diverticulitis	Irregular Heart Beat (specify)
High Blood Pressure	Asthma
Diabetes	Arthritis (specify)
COPD	Stroke
Kidney Disease (specify)	Sleep Apnea
Cancer (specify)	Reflux / Heart Burn
Ulcerative Colitis	Bleeding Disorder (specify)
Crohn's Disease	Depression
Heart Attack	Anxiety

Please list any other medical conditions you have that are not listed above:

____

____

PAST SURGICAL HISTORY: Please list ALL surgical procedures:

Have you ever had a colonoscopy? Yes No If so, Date? ______________

Where?______________________ Doctor's Name:________________________

SOCIAL HISTORY:

Do you drink alcohol? Yes No — If yes, how many drinks per week? ______________

Do you use smoke tobacco? Yes No — Have you ever smoked? ______________

Do you use illicit drugs? Yes No — If yes, please list: ______________

FAMILY HISTORY:

Has anyone in your family ever had colon or rectal cancer? Yes No

If yes, what is their relationship to you?______________________

Has anyone in your family ever had colon or rectal polyps? Yes No

If yes, what is their relationship to you?______________________

Any other health problems in your immediate family: ______________________

Name: ______________________________ DOB: ____________________

What pharmacy do you use? ______________________ **Location:** ________________

Have you ever had a pneumonia vaccination? **YES** **NO**

Are you currently taking or have you recently discontinued (in the last 2 weeks) any immunosuppressant medications? **YES** **NO**

Are you on any blood thinners? **YES** **NO** **If so, which one?** ________________

MEDICATIONS: Please list ALL of your medications including OTC or provide a list.

1.	11.	21.
2.	12.	22.
3.	13.	23.
4.	14.	24.
5.	15.	25.
6.	16.	26.
7.	17.	27.
8.	18.	28.
9.	19.	29.
10.	20.	30.

DRUG ALLERGIES:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

DOCTOR LIST: Please list all of your doctors and their specialty:

Primary:	
Cardiologist:	
Pulmonologist:	

Review of Systems: Circle all that apply.

GENERAL: Fever Chills Weight loss Weight gain Fatigue weakness
SKIN: Skin rash Skin sores
HEAD/NECK: Headache Swollen glands
LUNGS/HEART: Cough Wheezing Shortness of breath Chest pain Palpitations
URINARY: Urinary frequency Pain with urination
MUSCULOSKELETAL: Muscle or joint pain
NEUROLOGICAL: Fainting Numbness Tremors
HEMATOLOGIC: Easy bruising/bleeding History of clotting problems
GASTROINTESTINAL: Anorectal bleeding Anorectal pain Anorectal itching/burning Nausea Constipation Diarrhea Change in stool size Vomiting Change in bowel habits Fecal incontinence Blood in stool Heart burn Abdominal pain

Briefly state why you are being seen today:

____
____
____

Colon & Rectal Surgical Associates of Birmingham, P.C.

Printed Patient Name: ____

Email: ____

Social Security Number: ______________________________

(This is needed for any procedures or tests that may have to be scheduled with outside facilities.)

Below, please list any family member, friend, or other person that you give us permission to speak with concerning your healthcare. Doctors do not need to be included. If none apply, please write none.

Name	Relationship	Phone Number
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Do you have an advance directive? Yes No

If yes, please provide our office a copy.

If no, would you like us to provide you with one? ____________