Colon & Rectal SURGICAL ASSOCIATES of Birmingham, PC

Name: _____ DOB: _____

Reason for Appointment: (Please be specific)

_____

Have you received the Flu vaccine in the past year? NO YES **Month?**_____
Have you ever received a pneumonia vaccine? NO YES

Social History:

Do you smoke tobacco? NO YES **If yes, how often?** _____
Have you ever smoked? NO YES **If yes, when did you quit?** _____
Other tobacco products? NO YES **If yes, type and how much?** _____
Do you drink alcohol? NO YES **Beer, wine or liquor? How many a week?** _____

Medication Information:

Are you currently taking or have you recently discontinued (in the last 2 weeks) any immunosuppressant medications, such as Methotrexate, Prednisone, and Humira? NO YES Type: _____

Are you on any blood thinners? NO YES
If so which one? Aspirin Warfarin (Coumadin) Pradaxa Eliquis Xarelto

Plavix (Clopidogrel) Prasugrel Brilinta Cilostazol Aggrenox other: _____

What pharmacy do you use? _____ **Location:** _____

MEDICATIONS: Please list ALL of your medications including over-the-counter meds or provide a list

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Drug Allergies and Reactions:

Drug	*Reaction*	*Drug*	*Reaction*
1		6	
2		7	
3		8	
4		9	
5		10	

Medical History:

Primary Care Doctor: _____ **Gynecologist:** _____

Cardio/Pulmonary MD: _____ **Urologist:** _____

Gastroenterologist: _____ **Oncologist:** _____

Have you ever had a colonoscopy? NO YES
If so, Date: _____ **Where:** _____ **Doctor's Name:** _____

Have you ever had a flexible sigmoidoscopy? NO YES
If so, Date: _____ **Where:** _____ **Doctor's Name:** _____

Past Medical History: Check which ones **YOU** have been diagnosed with (all that apply)

Anxiety	Heart Attack
Arthritis (specify)	Heart Disease
Asthma	Hepatitis
Bipolar Disorder	HIV (AIDS)
Bleeding Disorder (specify)	High Blood Pressure
Benign Prostatic Hyperplasia	Irregular Heart Beat (specify)
Blood Clots (where)	Kidney Disease
Cancer (specify)	Reflux/Heartburn
CDIFF	Sleep Apnea
Colon or Rectal Cancer	Stroke
Colon Polyps	STD (specify)
COPD	Ulcerative Colitis
Crohn's Disease	Chronic UTIs
Depression	OTHER:
Diabetes	
Diverticulitis	
Diverticulosis	

Past Surgical History: (Please list **ALL** surgery procedures or provide list)

Family History: (Mother, Father, Brother, Sister, Son, Daughter)

Has anyone in your family ever had colon or rectal cancer? If so, who? _____

Has anyone in your family ever had colon polyps? If so, who? _____

Any other health problems in immediate family? If so, what and who?_____

_____

Review of Systems: (Circle ALL that apply)

General: Fever Chills Weight Loss Weight Gain Fatigue/Weakness

Skin: Rash Sores

Head/Neck: Headache Swollen Glands

Lungs/Heart: Cough Wheezing Shortness of Breath Chest Pain Palpitations

Urinary: Frequency Pain with Urination Urgency

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 – lower left – lower right – upper left – upper right

Other Problems:

_____

_____

_____

Colon & Rectal SURGICAL ASSOCIATES of Birmingham, PC

Printed Patient Name: _____

Social Security Number: _____ DOB: _____

Email: _____

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

Below, please list any family members, 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 advanced directive? NO YES

If yes, please provide our office a copy.

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