Colorectal Surgery Patient Questionnaire

Name: _____ DOB: _____ Date of visit: _____

Your best contact phone number_____

Reason for your visit: _____

Name of your gastroenterologist? _____

Address _____

Phone number _____

Name of your primary doctor? _____

Address_____

Phone number_____

Name of your preferred pharmacy? _____

Address_____

Phone number_____

What conditions have you ever had?

( ) Diabetes	( ) High blood pressure	( ) Stroke	( ) Atrial Fibrillation
( ) Heart disease	( ) Heart failure	( ) Heart attack	( ) Pacemaker
( ) Seizures	( ) High Cholesterol	( ) Sleep apnea	( ) Crohn's or Ulcerative Colitis
( ) Asthma	( ) Emphysema	( ) Arthritis	( ) Anxiety/Depression
( ) Hepatitis	( ) Colorectal polyps	( ) Stomach ulcer	( ) Abnormal heart rhythm
( ) Colon cancer	( ) Rectal cancer	( ) HIV	( ) Blood clot
( ) Kidney disease	( ) Thyroid disease	( ) Migraines	( ) Human Papilloma Virus- HPV
( ) Diverticulitis	( ) Prostate issues		

( ) other: _____

REVIEW OF SYSTEMS - please circle if you have or ever had any of the following:

Eyes:

Have your eyes turned yellow?	Yes	No	Do you have glaucoma?	Yes	No
Double vision?	Yes	No	Eye pain	Yes	No

Head, ears, nose, throat, neck:

Do you have loose teeth?	Yes	No	Frequent nose bleeds?	Yes	No
Chronic sinus problems?	Yes	No	Do you have sleep apnea?	Yes	No

Cardiac:

Do your legs ever swell up?	Yes	No	Does your heart ever flutter?	Yes	No
Do you ever have chest pain?	Yes	No	Ever get light headed?	Yes	No

Lungs:

Ever get short of breath?	Yes	No	Do you have a chronic cough?	Yes	No
Ever had Tuberculosis?	Yes	No			

Gastrointestinal:

Abdominal pain?	Yes	No	Blood in the stool?	Yes	No
Do you have nausea?	Yes	No	Do you have constipation?	Yes	No
Recent weight loss?	Yes	No	Change in bowel habits?	Yes	No
Uncontrolled stool or gas?	Yes	No	Do you have accidents?	Yes	No

Urinary:

Do you urinate often at night?	Yes	No	Is there blood in the urine?	Yes	No
Get urinary tract infections?	Yes	No	Hard to start a stream of urine?	Yes	No

Neurologic:

Do you have headaches?	Yes	No	Are you sensitive to light?	Yes	No
Any recent slurring of speech?	Yes	No	Memory loss?	Yes	No

Skin:

Any skin ulcers?	Yes	No	Any rash?	Yes	No

Psychiatric:

Feeling down or depressed?	Yes	No	Hearing voices?	Yes	No
Trouble concentrating?	Yes	No			

Hematology:

Bleeding problems?	Yes	No	Do you bruise easily?	Yes	No

Skeletal:

Difficulty walking?	Yes	No	Do your joints hurt?	Yes	No
Had a fall in the past 2 years?	Yes	No	Walk with a cane or walker?	Yes	No

List all of your prior surgeries: _____

_____

_____

List all allergies: _____

List all medications taken in the past year: _____

_____

_____

_____

Have you ever had radiation and why?_____

Do you smoke? No Yes How much? _____ I quit When? _____

Do you drink? No Yes How much? _____ I quit When? _____

Height _____ Weight _____

Who do you live with? _____

What type of work do you do? _____

Year of last colonoscopy? _____ What did it find? _____

Has anyone in your family had colorectal cancer? No Yes Who? _____

Has anyone in your family had colorectal polyps? No Yes Who? _____

Has anyone in your family had Crohn's or Ulcerative colitis? No Yes Who? _____

Has anyone in your family had uterine cancer? No Yes Who? _____

Has anyone in your family had anesthesia problems? No Yes Who? _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____