

# University Medical Group Department of Colon & Rectal Surgery

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

SSN: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacy name, number, & address: \_\_\_\_\_

Please list **MEDICATIONS** and **DOSAGE** amounts that you are currently taking. Please write "None" if you have no medications.

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What medications are you allergic to? Please write "None" if no allergies.

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Have you ever had any of the following medical problems? Please circle all that apply:

Anemia	Anxiety	Arthritis	Asthma	Back Pain	Blood clots	
Cancer (type)_____		HIV	Heart Disease	COPD	Crohn's Disease	
Diabetes	DVT	Dementia	Fibromyalgia	Hepatitis	High Blood Pressure	
Irritable Bowel		Kidney Failure		Kidney Stones	Migraines	Pacemaker
Parkinson's Disease		Pilonidal Cyst		Stroke		

List any other medical problems:

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Have you ever had any of the following surgical procedures? If so, circle all that apply:

Appendectomy	Back surgery	Colon surgery	Breast surgery	Heart Bypass
Heart Catheterization	Gall bladder	C section	D&C	Hemorrhoidectomy
Hernia Repair (groin, belly button, incisional, other)			Hip replacement (left right)	
Hysterectomy	Knee Surgery (left right)		Laparoscopy	Tonsils
Prostatectomy	TURP			

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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Patient Questionnaire Page 2

**List any other surgical procedures you have had:**

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**Do you have any of the following symptoms? Circle all that apply.**

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|---------------------------------|------------------|-------------------------|-------------------|----------|-----------|
| Trouble breathing               | Anxiety          | Abdominal pain/cramping | Back Pain         |          |           |
| Bleeding problems/easy bruising | Blood in stool   | Blood in urine          | Chest pain        |          |           |
| Chills                          | Confusion        | Constipation            | Depression        | Diarrhea | Dizziness |
| Frequent urination              | Heartburn/Reflux | Irregular Heartbeat     | Painful urination |          |           |
| Rectal Pain                     | Seizures         | Shortness of Breath     | Leakage of Urine  | Vomiting |           |
| Weakness                        | Weight Loss      |                         |                   |          |           |

**Do any of the following family members have any of the following diseases? Please circle all that apply.**

- |          |                     |              |               |                |         |
|----------|---------------------|--------------|---------------|----------------|---------|
| Mother:  | Colon/Rectal Cancer | Colon Polyps | Breast Cancer | Uterine Cancer | Colitis |
| Father:  | Colon/Rectal Cancer | Colon Polyps |               |                | Colitis |
| Sister:  | Colon/Rectal Cancer | Colon Polyps | Breast Cancer | Uterine Cancer | Colitis |
| Brother: | Colon/Rectal Cancer | Colon Polyps |               |                | Colitis |
| Child:   | Colon/Rectal Cancer | Colon Polyps |               |                | Colitis |

**Social History**

Do you smoke?      Yes    No    If so, how much? \_\_\_\_\_

Do you drink alcohol      Yes    No    If so, how much? \_\_\_\_\_