Texas Health Care

Colon & Rectal Surgery
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MEDICAL HISTORY

Patient's name: _____ **Reason for Office Visit**: _____

Current medications (including Aspirin, insulin, inhalers); you may attach an additional sheet if necessary.

Medication	Dose	How often?	Medication	Dose	How often?
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

Allergies (to medications or anesthetics); Check here if no allergies: ☐

Medication	Reaction (e.g. rash, breathing problems)	Medication	Reaction
1. _____	_____	2. _____	_____

Medical History (please check if you have, or have had, any of the following):

☐ High blood pressure
☐ High cholesterol
☐ Heart attack
☐ Other heart disease
Specify: _____
☐ Asthma as an adult
☐ Emphysema
☐ Diabetes
☐ Stroke
☐ Blood clots
☐ Cancer
State body location: _____
☐ Liver failure
☐ Kidney failure
☐ Ulcer disease
☐ Hepatitis
☐ HIV or AIDS
☐ Other medical conditions: _____
_____
_____
☐ Smoking: Current ☐ Former ☐ None ☐
Packages per day ____; Years ____
☐ Alcohol use: Current ☐ Former ☐ None ☐
Drinks per week ____; Years ____
☐ Family (blood relatives) history of:
☐ Colon or rectal cancer
☐ Colon or rectal polyps
☐ Colon or rectal inflammation/colitis
☐ Other diseases: _____
_____

Surgeries (list type of surgery and approximate year):

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

Symptoms Review (check beside symptoms you have regularly; if box is not checked, it is assumed you do not have symptom):

General:
☐ Weight loss
☐ Fever
☐ Inability to exercise

Head and Neck:
☐ Visual problems
☐ Hearing problems
☐ Headaches
☐ Neck masses/lumps
☐ Nose bleeding

Respiratory:
☐ Shortness of breath
☐ Cough
☐ Wheezing

Cardiac:
☐ Chest pain
☐ Palpitations
☐ Trouble lying down flat
☐ Waking up short of breath
☐ Heart murmur

Gastrointestinal:
☐ Trouble swallowing
☐ Heartburn
☐ Nausea or vomiting
☐ Abdominal pain/cramps
☐ Abdominal bloating
☐ Change in bowel habits

Breast
☐ Breast lumps/tenderness
☐ Breast discharge

Genitourinary:
☐ Pain on urination
☐ Frequent urination
☐ Urinary infections
☐ Incontinence of urine
☐ Blood in the urine
☐ ♀: Vaginal discharge

Musculoskeletal:
☐ Muscular weakness
☐ Swelling in arms/legs
☐ Arthritis

Skin
☐ Rashes
☐ Hair loss/Changes in hair

Neurologic:
☐ Seizures
☐ Dizziness/fainting
☐ Balance difficulties
☐ Memory/speech problem
☐ Numbness/tingling

Psychiatric:
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Previous psychiatric care

Endocrine:
☐ Heat/cold intolerance
☐ Increased thirst
☐ Excessive urination

Hematologic/Lympahtic:
☐ Anemia
☐ Bleeding tendency
☐ Lymph node swelling

Allergic:
☐ Reactions to food
☐ Reactions to blood transfusions

Patient signature _____ Date _____ Physician signature _____ Date _____