



ATLANTA COLON & RECTAL SURGERY, P.A.

Today's date: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_

Sex: M F

Race: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list all your **CURRENT MEDICATIONS AND DOSAGE:** \_\_\_\_\_  
(If you do not know the drug name, list the condition.) \_\_\_\_\_

Please list all your **DRUG ALLERGIES:** \_\_\_\_\_

**Social History**

Do you smoke? \_\_\_\_\_

Frequency \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_

Frequency \_\_\_\_\_

Do you take drugs? \_\_\_\_\_

Frequency \_\_\_\_\_

**Past Medical History**

Do you have any of the following conditions? (Please check all that apply.)

- Anemia
- Arthritis
- Asthma
- Bladder Infection
- Blood Disorder
  - DVT
  - Pulmonary Embolism
- Cancer
- Chickenpox/Measles/Mumps
- Colitis
- Crohn's Disease
- Diabetes
- Epilepsy
- Heart Disease
- Hemorrhoids
- Hepatitis
- Hernia
- High/Low Blood Pressure
- High/Low Cholesterol
- HIV +
- Irritable Bowel Syndrome
- Kidney Disease
- Migraine Headaches
- Mitral Valve Prolapse
- Pneumonia
- Scarlet Fever
- Smallpox
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcer
- Urinary
- Prostate
- Other History:

**Past Surgeries:** \_\_\_\_\_

**Family Medical History**

	Relative	Condition & Age	None
Family History of Cancer			
Family History of Colon Polyps/Tumors			
Family History of Colon Disease			

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

Date of Birth: \_\_\_\_\_

### Present Medical Complaints

Reason for your visit:

**Instructions: Please indicate your response to each item below with an "X". Any indication other than "yes" will be interpreted as a negative response.**

<u>Review of Systems</u>	No	Yes		No	Yes		No	Yes
<b>Constitutional</b>			<b>Cardiovascular</b>			<b>Neurological</b>		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath w/walking	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Light headed/dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion or seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Chronic coughing	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>		
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>			<b>Ear/Nose/Mouth/Throat</b>		
Rectal Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Protrusion from rectum	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness/swelling	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Walking	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<b>Integumentary (skin/breast)</b>			Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary</b>			Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic/Lymphatic</b>		
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>
Burning/Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence of urine	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes</b>			HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	Hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Eye disease/injury	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Male-Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>				Hyper/Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Female-vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Female-# of pregnancies _____								
Female-Stool through vagina	<input type="checkbox"/>	<input type="checkbox"/>						

How often do you move your bowels? \_\_\_\_\_ per day \_\_\_\_\_ per week

**Patient Statement: To the best of my knowledge, the above information is accurate and complete.**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician Statement: I have reviewed the questionnaire with the patient.**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_