



ATLANTA COLON & RECTAL SURGERY, P.A.

Today's date: _____

Patient Name: _____

Birth Date: _____

Race: _____

Marital Status: Single Married Widowed Divorced

Employer: _____

Spouse's Name: _____

Current Medications & 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

Have you ever experienced any of the following conditions? (Please check all that apply.)

- Anemia
- Asthma
- Bladder Infection
- DVT
- Pulmonary Embolism
- Cancer
- Colitis

- Crohn's Disease
- Diabetes
- Heart Disease
- Hepatitis
- High/Low Blood Pressure
- HIV +
- Kidney Disease

- Mitral Valve Prolapse
- Pneumonia
- Stroke
- Thyroid Disease
- Urinary / Prostate
- Other History:

Past Surgical History

Have you ever had a colonoscopy? Yes No

If yes, when _____ and results _____

Family Medical History

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

