Memorial Colon and Rectal Surgery

PATIENT HEALTH HISTORY

Patient Name _______________________ Date of Birth _____________________

Please list **ALL** medications you are currently taking and dosage, including non-prescription drugs (ex, vitamins, supplements, OTC remedies)

Medication	**Dosage**	**Medication**	**Dosage**
1. _________________	_______________	4. ________________	_______________
2. _________________	_______________	5. ________________	_______________
3. _________________	_______________	6. ________________	_______________

Do you take Aspirin, Advil, Ibuprofen, Aleve, or Naprosyn regularly? YES NO

SURGERY/ OPERATIONS	**DATE**	**SURGERY/ OPERATIONS**	**DATE**
1. ___________________	___/___/___	3.___________________	___/___/___
2. ___________________	___/___/___	4. ___________________	___/___/___

ALLERGIES

Please list any allergies to any food or medications

_____________________ ____________________ _____________________ ______________________

Do you smoke (cigarettes/cigars/marijuana)? YES NO # per day _____ Date started _______ Quit ______

Do you have any blood relatives who have had any of the following: PLEASE CIRCLE

CANCER HEART ATTACK DIABETES STROKE TUBERCULOSIS HIGH BLOOD PRESSURE

PERSONAL HISTORY

Circle all that apply

Tuberculosis Heart Disease Diabetes Cancer High Blood Pressure Heart Disease

Pneumonia COPD Asthma Gallbladder Disease Jaundice Hepatitis or HIV Anemia

Colitis or other bowel disease Hemorrhoids or any rectal disease Nephritis (kidney disease)

Bladder disease Any bones or joint disease Polio or Meningitits Any other disease

REVIEW OF SYMPTOMS Please indicate any **personal** history below PLEASE CIRCLE

ENDOCRINE

Glandular or hormone problem
Excessive thirst or urination
Heat or Cold Tolerance
Skin becoming dryer
Change in hat or glove size

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing
Earaches or drainage
Chronic sinus problems or rhinitis
Nose bleeds
Mouth Sores
Bleeding Gums
Sore throat or voice change
Swollen glands in neck

EXTREMETIES

Blue toes or fingers
Blood clots or phlebitis
Varicose veins
Pain in calves/thigh/buttocks when walking

SKIN

Non healing wound or injury
Mole changing or enlarging
Rash or Itching
Change in Skin Color
Change in hair or nails

EYES

Blurred or double vision
Wear glasses/contacts lenses

BREAST

Breast pain
Breast lump
Family history of breast Cancer
Take Birth control pills
Surgery on breast
Recent Mammogram
Breast discharge

MUSCOLOSKELETAL

Joint Pain
Joint Stiffness or Swelling
Weakness or muscle cramps
Back Pain

GASTROINTESTINAL

Rectal bleeding or blood in stool
Loss of appetite
Change in Bowel movements
Nausea or Vomiting
Frequent diarrhea
Painful bowel movements or constipation

GENITOURINARY

Frequent Urination
Burning or painful urination
Blood in urine
Incontinence or dribbling
Kidney stones

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Blood transfusion in the past
Enlarged glands

NEUROLOGICAL

Frequent or recurrent headaches
convulsions or seizures
Light headed or dizzy
Numbness or ringing sensations
Tremors
Paralysis
Head Injury

CONSTITUTIONAL SYMPTOMS

Good general health
Recent weight change

PSYCHIATRIC

Memory loss or confusion
Depression
Insomnia
Nervousness

CARDIOVASCULAR

Heart Trouble
Chest pain or angina pectoris
Palpitation
Shortness of Breath
Wheezing