Texas Health Care

**Colon & Rectal Surgery**
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## MEDICAL HISTORY

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

**Current medications** (incl. Aspirin, insulin, inhalers, eye drops, supplements); you may attach an additional sheet if necessary.

| | Medication | Dose | How often? | | Medication | Dose | How often? |
|---|---|---|---|---|---|---|---|
| 1. | | | | 5. | | | |
| 2. | | | | 6. | | | |
| 3. | | | | 7. | | | |
| 4. | | | | 8. | | | |

**Allergies** (to medications, anesthetics, topical agents); Check here if no allergies: ☐

1. _____ 2. _____ 3. _____ 4. _____

**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 ____
Caffeine: Current ☐ None ☐
Family history of any of these (and state who):
☐ Colorectal cancer: _____
☐ Colorectal polyps: _____
☐ Ulcerative colitis/Crohn's: _____
☐ Other diseases: _____

**Surgeries** (list type of surgery and approximate year):

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

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

**Constitutional:**
☐ Chills
☐ Fever
☐ Malaise (feel unwell)
☐ Weight loss

**Head and Neck:**
☐ Double vision
☐ Ear infections
☐ Eye pain
☐ Nasal congestion
☐ Sinus infections
☐ Sore throat

**Respiratory:**
☐ Shortness of breath
☐ Frequent cough
☐ Pain with deep breath
☐ Wheezing

**Cardiac:**
☐ Chest pain
☐ Swelling in legs (edema)
☐ Palpitations

**Gastrointestinal:**
☐ Abdominal pain
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Trouble swallowing
☐ Heartburn
☐ Vomiting blood
☐ Blood in stool
☐ Loss of appetite
☐ Black-colored stools
☐ Nausea
☐ Reflux (heartburn)
☐ Vomiting

**Genitourinary:**
☐ Painful urination
☐ Blood in urine
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention

**Reproductive (female):**
☐ Breast lumps
☐ Breast pain
☐ Vaginal discharge

**Metabolic/Endocrine:**
☐ Cold intolerance
☐ Excessive thirst
☐ Heat intolerance

**Neurologic:**
☐ Dizziness
☐ Headache
☐ Numbness
☐ Tremors
☐ Spinning sensation

**Psychiatric:**
☐ Anxiety
☐ Depression
☐ Increased stress
☐ Prev. psychiatric care

**Skin:**
☐ Contact allergy
☐ Hives
☐ Pruritus (itching)
☐ Rash

**Musculoskeletal:**
☐ Back pain
☐ Myalgia (muscle pains)
☐ Joint pain

**Hematologic/Lymphatic:**
☐ Easy bleeding
☐ Easy bruising
☐ Swollen lymph nodes

**Immunologic:**
☐ Asthma
☐ Chemicals at wkplace
☐ Food allergies
☐ Immunosupression
☐ Seasonal allergies

Patient signature _____ Date _____ Physician signature _____ Date _____