ALASKA COLORECTAL SURGERY

2751 DeBarr Road, Suite 280
Anchorage, AK 99508
(907) 222-1401

Name: _____ **Age**: _____ Male / Female **Date**: _____

Referred by: _____ ***Primary Doctor:*** _____

What Problem brings you here?_____

_____

_

Colon History

Have you ever had a Colonoscopy or Sigmoidoscopy? Yes No. If so, when? _____

Do you use a Fiber Supplement? Yes No. How often?_____ Brand _____

Do you use Laxatives? Yes No How often? _____ Brand _____

Anesthesia History

Have you ever had difficulties with anesthesia or sedation: Yes No If yes what _____

Do you require antibiotics before dental work? Yes No

In the last 3 months have you taken steroid medication (inhaled or oral): Yes No

***Past* Medical Conditions**

(circle all that apply)

Anorectal Fissures	Diabetes	Hiatal Hernia	Pneumonia
Anorectal Fistula	Diarrhea	High blood pressure	Prostate Disease
Asthma	Diverticulosis	High Cholesterol	Rheumatic Fever
Anemia	Dizziness	Hyperthyroid	Seizures
Arthritis	Emphysema	Hypothyroid	Stroke
Back pain	Epilepsy	Insufficiency Vein	Tuberculosis
Bladder infection	Fainting	Irritable Bowel	Ulcerative colitis
Blood in Urine	Gallstones	Jaundice	
Blood transfusion	Gastric reflux	Kidney Failure	Other: _____
Bronchitis	Glaucoma	Kidney stones	Other: _____
Cancer Type_____	Gout	Lactose Intolerance	Other: _____
Cataracts	Hard of hearing	Liver Problems	
Chest pain	Headaches Migraine Tension	Lower Leg Wounds	
Colorectal Cancer	Heart arrhythmia	Lupus	
Constipation	Heart attack	Osteoporosis	
Crohn's Disease	Hemorrhoids	Pancreatitis	
Depression/Anxiety	Hepatitis Type _____	Peripheral Neuropathy	

Surgical History:

YEAR	REASON	YEAR	REASON

Pregnancy History:

Number of pregnancies? _____ Number of vaginal births? _____ Number of C-sections? _____

Last menstrual period: _____

Current Medications:

MEDICATIONS	VITAMINS / HERBS

Are you currently under a Pain Contract? Y N

Contracting Physician:_____ Phone #: _____

Allergy History:

Medical Allergies:	
Latex? Y N	**Adhesive Tape? Y N**

Family History:

Does your family history include any of the following?

Colorectal Cancer, Polyps, Crohn's Disease, Colitis, Diabetes, Stroke, Other Cancer(s) (Type), Heart Disease, High Blood Pressure, or Thyroid Problems

Family Member	Disease/disorders	Family member	Disease/disorder
Mother		Maternal Grandmother	
Father		Maternal Grandfather	
Brother/sister		Paternal Grandmother	
Brother/Sister		Paternal Grandfather	
Brother/Sister		***Unknown:*** Adopted	
Brother/Sister			

Social History:

Single ___ Married ___ Divorced ___ Widowed ____ Other:_____

Live with: Spouse/Significant Other ____ Family ____ Alone ____

Are you employed? Yes No Full-time _____ Part-time _____ Student _____

Occupation: _____

How often do you drink alcohol? Never _____ per day _____ per week _____ per year _____

Use recreational Drugs? Yes No If yes, what type _____ How often? _____

Caffeinated drinks per day: Coffee _____ Tea _____ Sodas _____

Tobacco: Never smoked / chewed
Currently smoke / chew: _____ per day Since: _____
Previous smoker / chewer: _____ per day Year Quit: _____ Years Smoked / Chew_____

Please circle all symptoms you are <u>currently</u> experiencing:

<u>General:</u>

Fever Chills Sweats Fatigue Poor appetite Weight loss (10 lbs in 3 month) Weight gained (10 lbs last 3 months)

<u>Eyes:</u>

Difficulty seeing Wears: Glasses or Contacts

<u>Ear/Nose/Throat:</u>

Ear ache Decreased hearing Nose bleeds Sore throat Hoarseness Difficulty swallowing

<u>Cardiovascular:</u>

Chest pain Palpitations Shortness of breath: (W/ exertion W/O Exertion At night) Fainting

Lower Leg Swelling

<u>Respiratory:</u>

Cough Difficulty in breathing Coughing up blood Wheezing

<u>Gastrointestinal:</u>

Nausea Diarrhea: (Watery Loose) Mucus in stool Constipation Bloating Blood in stool
Blood w/ wiping Blood dripping into toilet Change in bowel pattern Abdominal Pain Unintentional loss of feces

<u>Genitourinary:</u>

Pain w/urination Blood in urine Urinary frequency Frequent night urination Hesitancy w/ starting stream
Unintentional loss of urine Genital sores

<u>Musculoskeletal:</u>

Back Pain Joint pain Joint swelling Muscle cramps Muscles weakness Stiffness

<u>Skin:</u>

Open wounds Lesions Rash Itching

<u>Neurologic:</u>

Paralysis Weakness Numbness Seizures Tremors Dizziness

<u>Psychiatric:</u>

Depressed mood Anxiety Memory loss

Endocrine:

Cold intolerance Heat Intolerance Thirsty all the time Hungry all the time

Heme/Lymphatic:

Easy bruising Bleeding gums Enlarge lymph nodes Recurrent infections Anemia

Name: _____ Date: _____