ALASKA COLORECTAL SURGERY

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

**Name**: _____ **Age**: _____ Ma**le / 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 RashItching

***<u>Neurologic:</u>***

Paralysis Weakness Numbness Seizures Tremors Dizziness

***<u>Psychiatric:</u>***

Depressed mood Anxiety Memory loss

***<u>Endocrine:</u>***

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

***Heme/Lymphatic:***

Easy bruising Bleeding gums Enlarge lymph nodes Recurrent infections Anemia