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	

Have you been vaccinated against Covid 19: Yes No

If yes, which type: Pfizer Moderna Johnson & Johnson

 Name: ______________________ Date: ________

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

Other Providers:

Do you have a GI Physician: Y N I agree to call my GI and have them send any records as requested: Y N NA
Physician name:_____________________________________ Phone #:__________________________________

- **Please contact your GI office and have them provide your last note and colonoscopy—our fax: 907-222-1402**

Do you have a Cardiologist: Y N I agree to call my cardiologist and have them send any records as requested: Y N NA
Physician name:_____________________________________ Phone #:__________________________________

- **Please contact your cardiologist office and have them provide your last note—our fax: 907-222-1402**

Are you currently on a pain contract: Y N
Physician name:_____________________________________ 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			

Name: ____________________________ Date: _________

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 __currently__ experiencing:

General:

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

Eyes:

Difficulty seeing Wears: Glasses or Contacts

Ear/Nose/Throat:

Ear ache Decreased hearing Nose bleeds Sore throat Hoarseness Difficulty swallowing

Cardiovascular:

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

Lower Leg Swelling

Respiratory:

Cough Difficulty in breathing Coughing up blood Wheezing

Gastrointestinal:

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

Genitourinary:

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

Musculoskeletal:

Back Pain Joint pain Joint swelling Muscle cramps Muscles weakness Stiffness

Skin:

Open wounds Lesions Rash Itching

 Name: ____________________________ Date: _________

Neurologic:

Paralysis   Weakness   Numbness   Seizures   Tremors   Dizziness

Psychiatric:

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: __________