Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 1

PATIENT NAME:______________________________________**DATE OF BIRTH:**___________________________

TODAY'S DATE:__________________ **PATIENT'S HEIGHT:**__________________ **WEIGHT:**________________

State the reason why you are here, complaint, symptoms and duration: ____

____

Do you have, or have you in the past had, any of the conditions listed below:

Yes No Colon or Rectal Cancer (please circle which one). → If yes, age when diagnosed:_______________
Yes No Colon or Rectal Polyps (please circle which one). → If yes, age when diagnosed:_______________
Yes No Personal history of any other type of cancer. → If yes, age when diagnosed:___________________
What type?____
Yes ☐ No ☐ Radiation treatments for cancer What Type of Cancer?______________________________________
Yes ☐ No ☐ Have you taken steroids (Prednisone, etc.) in the last 30 days?
Yes ☐ No ☐ Have you taken aspirin or non-steroidal anti-inflammatory drugs (Ibuprofen, Motrin, etc.) in the last seven days?
Yes ☐ No ☐ Thyroid problems
Yes ☐ No ☐ Diabetes (Type?________)
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Recent fevers

Digestive System:
Yes ☐ No ☐ Inflammatory bowel disease (Crohn's disease or Ulcerative Colitis)
Yes ☐ No ☐ Diverticulitis
Yes ☐ No ☐ Diverticulosis
Yes ☐ No ☐ Rectal bleeding
(Describe the bleeding:______________________________)
Yes ☐ No ☐ Constipation, diarrhea, or a change in bowel habits
Yes ☐ No ☐ Fecal incontinence
Yes ☐ No ☐ Weight loss
Yes ☐ No ☐ Ulcers in the mouth
Yes ☐ No ☐ Ulcer of the stomach or duodenum (small intestine)
Yes ☐ No ☐ Gallbladder disease or gallstones
Yes ☐ No ☐ Liver disease or cirrhosis
Yes ☐ No ☐ Diseases of the pancreas
Yes ☐ No ☐ Gastritis (inflammation of the stomach)

Genitourinary System:
Yes ☐ No ☐ Kidney failure/dialysis
Yes ☐ No ☐ Urinary or prostate problems
Yes ☐ No ☐ Impotence
Yes ☐ No ☐ Do you have children?
Vaginal deliveries? Yes ☐ No ☐
Episiotomies? Yes ☐ No ☐
Cesarean Sections? Yes ☐ No ☐

Pulmonary System:
Yes ☐ No ☐ Asthma or emphysema
Yes ☐ No ☐ Pneumonia
Yes ☐ No ☐ Sleep apnea – If yes, do you require a CPAP? Yes ☐ No ☐

Cardiovascular System:
Yes ☐ No ☐ Defibrillator
Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Chest pain or angina
Yes ☐ No ☐ Myocardial infarction (heart attack) When?_______________________
Yes ☐ No ☐ Palpitations or arrhythmias
Yes ☐ No ☐ Hypertension (high blood pressure)
Yes ☐ No ☐ Claudication (poor blood flow to the legs)
Yes No Blood clot in the legs
Yes No Blood clot in the lungs (pulmonary embolism)
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Previous organ transplant
Yes ☐ No ☐ Blood Disorder
Yes ☐ No ☐ HIV Positive
Yes ☐ No ☐ Previous blood transfusion
Yes ☐ No ☐ Easy bleeding or bruising
Yes ☐ No ☐ Anemia

Nervous System:
Yes ☐ No ☐ Neurologic illness
Yes ☐ No ☐ Psychiatric illness
Yes ☐ No ☐ Iritis (inflammation of the eyes)
Yes ☐ No ☐ Blindness

OTHER:____

____

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COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 2

PATIENT NAME:____**DATE OF BIRTH:**_____________________

TODAY'S DATE:____

SURGICAL HISTORY

Yes ☐ No ☐ Previous colon or rectal surgery (please list below)
Yes ☐ No ☐ Previous abdominal surgery (please list below)
Yes ☐ No ☐ Previous anal surgery (please list below)
Yes ☐ No ☐ Previous heart surgery (please list below)
Yes ☐ No ☐ Previous Knee/Hip/Joint Replacement (please indicate which joint and whether it was left or right side):____Date:________________________
Yes ☐ No ☐ Have you ever had a Colonoscopy? (Date:_________________Facility:_________________________ Doctor:_____________________)

<u>LIST ALL PREVIOUS OPERATIONS (INCLUDE DATES IF POSSIBLE):</u>________________________________

____

____

Yes ☐ No ☐ Have you ever had a Barium Enema? (Date:_______________________________________)
Yes ☐ No ☐ Have you ever had a CT Scan (Date:_____________Reason:_________________________)

FAMILY HISTORY

Please indicate if the family member is on the Paternal or Maternal side of your family

Yes ☐ No ☐ Do you have <u>three or more relatives</u> with Colon or Rectal cancer?

Please list anyone in your family with the following (please indicate N/A if no one in your family applies):

- Colon or Rectal cancer (please circle which one):
  - Who?____
- Colon or Rectal polyps
  - Who?____
- Any other type of cancer
  - Who?____
  - What type?____

Yes ☐ No ☐ Does anyone in your family have Inflammatory Bowel Disease (Crohn's disease or Ulcerative Colitis)
Yes ☐ No ☐ Do you have a first degree relative (parent, sibling, or child) who, <u>before the age of 50</u>, was diagnosed with cancer?
If yes, who?_______________________What type of cancer?_________________Age at diagnosis?________

SOCIAL HISTORY

Yes ☐ No ☐ Do you smoke cigarettes currently? Packs/day________________
Yes ☐ No ☐ Have you ever smoked? When did you quit:_______________
Yes ☐ No ☐ Do you drink alcohol? Drinks/week_____________________
Yes ☐ No ☐ Have you ever been treated for substance abuse (alcohol, opioids, Etc.)?
What substance?_____________________________
Yes ☐ No ☐ Have you ever used intravenous (IV) drugs?

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COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 3

PATIENT NAME:_________________________________**DATE OF BIRTH:**__________________________

MEDICATIONS

☐ I take **NO** medications (prescription or over-the-counter) or any vitamins/supplements.

LIST ALL PRESCRIPTION MEDICATIONS:

NAME	DOSE	FREQUENCY

LIST ALL OVER-THE-COUNTER MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

NAME	DOSE	FREQUENCY

ALLERGIES

Yes ☐ No ☐ Do you have any allergies?

LIST ALL ALLERGIES AND YOUR REACTIONS (Medications, Latex, Shellfish, Etc.):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

PATIENT SIGNATURE:__________________________________**TODAY'S DATE:**________________________