MR#
Name of Patient
Date of Birth
Place Label Here

Surgery Faculty Practice
COLON & RECTAL SURGERY
2221 Stockton Blvd., Suite E
Sacramento, CA 95817
(916) 734-2680
Fax (916) 734-7613
http://www.ucdmc.ucdavis.edu/surgery/specialties/colorectal

NEW PATIENT HISTORY FORM

Name:	**Date of Birth:**
Referring Physician:	**Primary Care Physician:**
Any other physician who should receive an update of your records?	

Why are you here today?

COLON & ANORECTAL HISTORY

	RECTAL BLEEDING	ANAL PAIN	RECTAL DRAINAGE	ANAL MASS	ABDOMINAL PAIN
1. Do you have any of the following?	☐	☐	☐	☐	☐
2. For how long? *(days, weeks, months, yrs.)*					
3. What makes it better and what makes it worse?					
4. Any other relevant details?	☐ Bright Red ☐ Maroon ☐ On Stool ☐ Mixed in Stool ☐ In toilet water ☐ On toilet paper	☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning	☐ Pus ☐ Stool ☐ Yellow Fluid ☐ Mucous	☐ Firm ☐ Soft ☐ Growing ☐ Shrinking	☐ Upper ☐ Lower ☐ Right ☐ Left ☐ Middle ☐ Dull ☐ Sharp

	YES	NO
5. Have you lost any weight?		
If yes, how many pounds _______ *Over How much time* _______		
Why did you lose weight: Pain Dieting Exercising Loss of Appetite		
Other: ______________________________		
6. Number of BMs: __________ per day OR per week		
Are they: Hard Soft Mushy Liquid		
Any problems with control of solid stool?		
Any problems with control of liquid stool?		
Any problems with control of gas?		
7. Do you take: Fiber Laxatives Anti-Diarrhea		
What kind of fiber, laxative, and or anti-diarrhea medications do you take? ______________________________		
How often do you take it? ____________________		
8. Do you use medications on your anus?		
If yes, what kind ____________ *How often?* ____________		

	YES	NO
9. Have you ever had anal surgery?		
What procedure(s)? ______________________________		
Where? ____________________ *When?* __________		
10. Do you have a stoma? (If yes answer a.)		
a. Do you want to see a stoma therapist?		
11. Do you need to see a wound nurse?		
12. Have you ever had a colonoscopy?		
What Year(s)? ____________ *Where?* __________		
Did it show anything abnormal?		
13. Has your symptoms changed since your last scope?		
14. Have you ever had a barium enema study?		
What Year(s)? ____________ *Where?* __________		
Did it show anything abnormal?		
15. Have you ever had colon polyps?		
16. Did you ever have 10 or more polyps?		

Name: ________________________________

PAST MEDICAL HISTORY

17. Please list all medical problems/issues:

PAST SURGICAL HISTORY

18. Please list all your previous operations:	Date	Hospital

MEDICATIONS

	YES	NO
19. Are you allergic to any medicines/foods/agents?		
If so, please list:		

20. Please list all medications, supplements, you take regularly *(If you were seen at UC Davis prior, please skip this section)*:

Name	***Dose***	***Times per day***

FAMILY HISTORY

	YES	NO
21. Any relatives with Crohn's or Ulcerative Colitis?		
Please list who and which disease:		
22. Any relatives with a history of cancer?		

Relative	How many had cancer?	What type of cancer?	How many had Cancer < 50yrs. old	How many are alive?
Mother				
Maternal Grandmother				
Maternal Grandfather				
Maternal Aunt(s)				
Maternal Uncle(s)				
Maternal Cousins				
Father				
Paternal Grandmother				
Paternal Grandfather				
Paternal Aunt(s)				
Paternal Uncle(s)				
Paternal Cousin(s)				
Niece/Nephew(s)				
Siblings				
Children				
Grandchildren				

Name: ______________________________

SOCIAL HISTORY		YES	NO
23.	Are you: Single / Married / Partnered / Divorced / Widowed		
24.	Do You Live Alone?		
25.	Difficulty w/ transportation home after surgery?		
26.	Difficulty arranging help at home after surgery?		
27.	If you are disabled, why? ______________________________ *If not, what do you do for a living?* ______________________		
28.	Do you currently or have you ever smoked?		
	When did you start smoking? ________________ *How many packs per day?* ________________		
29.	Have you quit smoking? **OR** Would you like aids/help to quit smoking?		
30.	Do you use any of the following? Hooka Pipe Vapor Cigarettes Marijuana Smokeless Tobacco/Chew E-Cigarettes *Started?* ______________ *Quit?* ________________ *How often?* ______________________________________		
31.	How many alcoholic drinks do you have per week? ___________		
32.	Do you drink alcohol daily?		
33.	Do you get shaky if you do not drink for 3 days?		
34.	Do you use any recreational drugs?		
	If yes, list what they are: ________________________________		
35.	Have you used drugs in the last 3 months?		

GYNECOLOGICAL HISTORY (Women)		YES	NO
36.	Have you ever had an abnormal pap smear?		
	If yes, when? ____________________________________		
37.	How many times have you been pregnant? ________________		
38.	How many times have you given birth? ___________________		
39.	Forceps or Vacuum deliveries?		
40.	Vaginal Injury/tear, or episiotomy?		

WITHIN THE PAST 6 MONTHS		YES	NO
41.	**In the last 6 months have you had:**		
	Difficulty climbing 2 flights of stairs due to shortness of breath?		
	Daily cough with mucous production?		
	Chest Pain?		
	Nausea?		
	Vomiting?		
	Decreased appetite?		
	Fatigue / Weakness		
	Excessive thirst?		
	Urinary Frequency?		
	Urinary Urgency?		
	Trouble starting or stopping urine stream?		
	Urinary incontinence?		
	Getting up at night to urinate?		
	Painful urination?		
	Pass air with urine?		
	Pain with sex?		
	MEN: *Problems achieving an erection?*		
	MEN: *Problems achieving ejaculation?*		
	Problems achieving orgasm?		
	WOMEN: *Stool from vagina?*		
	WOMEN: *Gas from vagina?*		
	Have you fallen?		
	Arthritis, Joint Pain?		
	Anxiety / Excessive worry?		
	Anemia?		
	Fevers?		

Name: ______________________________

WITHIN THE PAST 6 MONTHS	YES	NO
42. **In the last 6 months have you had:**		
Chills?		
Night Sweats?		
Difficulty Hearing?		
Limited Movement of Neck or Jaw?		
Problems with Teeth?		
Oral ulcers / Canker Sores?		
Difficulty Walking 2 Blocks due to Shortness of Breath?		
Rashes?		
Antibiotics?		
If so, what kind? ______________________________		

	YES	NO
43a. **Have you ever had:**		
Bronchitis?		
Tuberculosis?		
Emphysema?		
Angina?		
Heart Attack?		
If yes, when? ______________________________		
Leg Swelling?		
Congestive Heart Failure?		
Sleep on 2+ pillows or wake up due to shortness of breath?		
High Blood Pressure / Hypertension?		
Difficulty walking 2 blocks due to leg pain?		
Difficulty walking 2 flights of stairs due to leg pain?		
Heart murmur?		
Irregular Heart Rhythm?		

HAVE YOU EVER HAD (Continued)	YES	NO
43b. **Have you ever had:**		
Atrial Fibrillation?		
Mitral Valve Prolapse?		
Liver Disease / Cirrhosis?		
Hepatitis / Jaundice?		
Diabetes?		
Problems with: High Blood Sugar		
Low Blood Sugar		
Sexually Transmitted Disease(s)		
If so which and when? ______________________		
Steroid use, oral or intravenous?		
If so when and why? ______________________		
Seizure, Epilepsy?		
If yes how often? ______________________		
If yes, Last Seizure? ______________________		
Stroke, TIA, fleeting blindness?		
When? ______________________________		
Ankylosing Spondylitis?		
Psychiatric treatment with medication?		
Claustrophobia?		
Depression?		
Bleeding Problems?		
Blood Clots?		
Where? (i.e. Arm, Lung) __________ *When?* __________		
Need antibiotics before dental procedures?		
Have you ever had a family member get a high fever due to anesthesia (Malignant Hypertension)?		
If yes, who: ______________ *When?* __________		
Have you had any problems with previous surgeries due to intubations?		
Any other problems with Anesthesia ____________________		

44. Anything else we should know about your health:

PLEASE RETURN THIS FORM TO THE FRONT DESK SO WE CAN THEN PLACE YOU IN AN EXAM ROOM.