Medical History

Name_______________________________________ Today's Date__________________

Reason for Today's Visit____

HEALTH QUESTIONNAIRE Please check the boxes if you have ever been diagnosed with.
Please read carefully and underline which type.

- ☐ Alcoholism
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Disorders or Anemia
- ☐ Bronchitis (Current)
- ☐ Cancer-specify________
- ☐ Cataracts(list surgery below)
- ☐ Colitis
- ☐ Colonic Polyps
- ☐ Crohn's Disease
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (type1/type 2)
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Fibrocystic Breast Disease
- ☐ Fissure
- ☐ Gallstones
- ☐ Glaucoma
- ☐ GERD
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypothyroidism/Hyper
- ☐ Incontinence (fecal/urinary)
- ☐ Irregular Heart Beat-specify______________
- ☐ Kidney Disease/Stone
- ☐ Liver Disease/Hepatitis
- ☐ Mental Illness-specify__
- ☐ Migraines/Headaches
- ☐ Pneumonia (current)
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Gastric Ulcers
- ☐ Urine Infections

☐ Other Medical History ____

Current Problems?

	Yes	No
Weight Loss/Gain	___	___
Fever	___	___
Fatigue	___	___
Hearing change	___	___
Nose bleeds	___	___
Visual change	___	___
Sore throat	___	___
Chest Pain	___	___
Shortness of breath	___	___
Wheezing	___	___

	Yes	No
Joint Pain	___	___
Joint swelling	___	___
Skin rash	___	___
Headaches	___	___
Dizziness	___	___
Insomnia	___	___
Urinary frequency	___	___
Burning	___	___
Blood in urine	___	___

	Yes	No
Change in bowels	___	___
Constipation	___	___
Abdominal Pain	___	___
Diarrhea	___	___
Rectal Bleeding	___	___
Dark stools	___	___
Rectal Pain	___	___
Rectal Burning	___	___
Rectal Itching	___	___
Fecal Incontinence	___	___
Nausea	___	___
Vomiting	___	___

LIST ALL THE MEDICATIONS, DOSAGE AND FREQUENCY TAKEN

If you have a copy of your list of medications, please give a copy to the front desk.
(If more space is needed please ask the front desk for another form.

Medication Name	Dosage (mg)	Frequency (daily, tablets or capsules)

List more on the back side of this sheet. Thank You.

Medication Allergies and reactions:____

Type of Allergy: **Latex** **Iodine** **Contrast**

Health Screening

Have you ever had a mammography? (Indicate date and results)________________________

Have you ever had a colonoscopy/flexible sigmoidoscopy? (Indicate date, results & MD)

____

Have you ever had a prostate screening or PSA level? (Indicate date, results & MD)

____

Surgical History & Years

- ☐ Appendectomy ______
- ☐ Breast Surgery ______
- ☐ Gall Bladder Removal ______
- ☐ Hernia Repair ______
- ☐ Cardiac Cath ______
- ☐ Pacemaker ______
- ☐ Heart Stent(s) ______
- ☐ Hysterectomy ______
  Complete or Partial
- ☐ Colon/Small Bowel ______
  (Specify) __________________
- ☐ Previous Anorectal Surgery ______
  (Specify) __________________

☐ Other Surgeries or Procedures & Years

____
____
____
____
____
____
____
____
____
____

Family History

☐ Colorectal Cancer Family member affected: ______________________________

Other Cancers in the family:

☐ Breast ☐ Prostate ☐ Stomach ☐ Uterine ☐ Ovarian ☐ Brain ☐ Bladder ☐ Other (Specify)
____

No family history of malignancies ☐

Any Falls in the last year? Yes No #____ injury with fall? ____

Other Family Medical Disorders

Specify: F-Father, M-Mother, B-Brother, S-Sister, D-Daughter, SS-Son

Bleeding Problems	_________	Kidney Disease	_________	Mother- Alive or Deceased
Asthma	_________	Colonic Polyps	_________	Cause of death__________________
Hypertension	_________	Diverticulitis disease	_________	Father- Alive or Deceased
Hypercholesterolemia	_________	Ulcerative Colitis	_________	Cause of death__________________
Diabetes	_________	Crohn’s Disease	_________	
Heart Attack	_________	Colitis	________	

Social History

☐ Single ☐ Married ☐Divorced/Separated ☐Widowed

Children #___________

Work ☐Yes ☐No ☐Retired Occupation:________________

Smoke: ☐ Yes ☐ No ☐ Former **Pack/Day** __________

Social Drugs: ____________________________

Alcohol: ☐ Yes ☐ No

☐ Monthly #_____ ☐ Daily #_____ ☐ Socially #_____

Height: _______ft ______in **Weight:** ___________lbs

Any dietary restrictions: ☐ Yes ☐ No

Explain: _________________________

Obstetrical and Gynecological History

Pregnancies #__________ Last Pap Smear/Pelvic Exam ___________

Deliveries #__________ C-section ______Vaginal delivery _____ Forceps _______ Episiotomy ___________

Last Menstrual Period ____/____/______

PATIENT REGISTRATION FORM
WELCOME TO OUR PRACTICE

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
PLEASE PRINT. *ALL INFORMATION WILL BE CONFIDENTIAL.*

PATIENT INFORMATION (CONFIDENTIAL)

NAME ______________________ AGE ________ DATE OF BIRTH ______________
ADDRESS ______________________ SEX ________ MARITAL STATUS ______________
CITY __________ STATE ________ ZIP ________ EMAIL ADDRESS: ______________
HOME PHONE ______________________ REFERRED BY WHOM ______________
CELL PHONE ______________________ PRIMARY PHYSICIAN ______________
SOCIAL SECURITY # ______________________ **PERMANENT ADDRESS** (IF DIFFERENT)
EMPLOYER ______________________ ADDRESS ______________
ADDRESS ______________________ CITY __________ STATE ________ ZIP ________
CITY __________ STATE ________ ZIP ________ PHONE # ______________
WORK PHONE ______________________ OCCUPATION ______________
PHARMACY NAME & PHONE ______________________________________

WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS UNDER FEDERAL GUIDELINES. IF YOU CHOOSE "I PREFER NOT TO ANSWER" PLEASE BE ASSURED THAT NO ADVERSE ACTION WILL BE TAKEN BY ANYONE IN THIS OFFICE.

RACE __________ **ETHNICITY __________ LANGUAGE __________ I PREFER NOT TO ANSWER ________

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)
NAME ______________________ BIRTHDATE ______________
SOCIAL SECURITY # ______________________ RELATION TO PATIENT ______________

PERMISSION FOR VERBAL COMMUNICATIONS

I permit West Valley Colon & Rectal Surgery Center, LLC, its physicians, nurses and other personnel to discuss health, medical, and/or billing information, in person or by telephone, with the following individuals listed below. (List individuals and state the person's relationship to the patient):

OR

I decline to give a name at this time ☐

	Name	Phone Number	Relationship
1.	______________	______________	______________
2.	______________	______________	______________
3.	______________	______________	______________

This document does not permit release of any written health information to the individuals named above. Release of information under this document is limited to verbal discussions only.

If, at any time, I do not want verbal discussions to be permitted between West Valley Colon & Rectal Surgery Center, LLC and any of the individuals named above, I must notify West Valley Colon & Rectal Surgery Center, LLC in writing or by calling (623) 875-7330 and speaking with the Practice Office Manager.

***Signature ______________________________

Date ______________________