Oakland Colon and Rectal Associates, P.C.
Patient Questionnaire

Date: _____

First Name: _____ **Last Name:** _____ **DOB:** _____

Referring Physician Name: _____ **Phone:** _____

Primary Care Physician Name: _____ **Phone:** _____

Reason for Visit Today: _____

COLONOSCOPY HISTORY: ☐ **No Previous Colonoscopy**

Past Colonoscopies: Location and approx. dates: _____
By which physician: _____

DO YOU HAVE ANY OF THE FOLLOWING: Check *SIGNIFICANT* complaints

( ) Rectal bleeding: ( ) Bright red ( ) Dark Red ( ) Toilet paper ( ) Into toilet bowl
( ) Mixed with stool ( ) On undergarments ( ) Positive on stool culture

( ) Rectal pain: ( ) Constant ( ) With bowel movements ( ) Sharp/dull burning

( ) Rectal problems: ( ) Hemorrhoids ( ) Rectal itching ( ) Soiling undergarments

Other rectal concerns: _____

( ) Abdominal pain: ( ) Cramping ( ) Bloating

Weight Change: ☐ **No Previous Weight Change**
____ Weight Loss _____ ____Weight Gain _____ ____Loss of Appetite

HAVE YOU HAD A CHANGE IN BOWEL HABITS? HOW LONG: _____
____ Diarrhea ____ Constipation ____Mucous with/without bowel movements
____ Laxative use: Name of laxative: _____ How Often _____ How long used _____

SURGICAL CONDITIONS - Please check all that apply

( ) Anal Fissure
( ) Breast Cancer
( ) Breast Mass
( ) Burn Injury
( ) Cholelithliasis
( ) Colon Cancer
( ) Colon Polyps
( ) Diverticulosis
( ) Fibrocystic Breast
( ) GI Bleed
( ) Liver Primary Cancer
( ) Pancreatic Cancer
( ) Pancreatitis
( ) Rectal Bleeding
( ) Small Intestine Cancer
( ) Stomach Cancer
( ) Thyroid Nodule
( ) Wound dehiscence
( ) Wound Infection

MEDICAL CONDITIONS

( ) Abnormal ECG
( ) Alcoholism
( ) Anemia
( ) Asthma
( ) Blood Transfusion
( ) Cancer
( ) CHF
( ) Cirrhosis
( ) Clotting Disorder
( ) COPD
( ) Coronary Artery Disease
( ) Deep Vein Thrombosis
( ) Diabetes Mellitus
( ) Hepatitis
( ) HIV/AIDS
( ) Hypertension
( ) Kidney Disease
( ) Liver Disease
( ) Myocardial Infarction
( ) Pulmonary Arterial Hypertension
( ) Seizures
( ) Sickle Cell Anemia
( ) Stroke
( ) Substance Abuse
( ) TIA

ANESTHESIA HISTORY

( ) Difficult Intubation
( ) Malignant Hyperthermia
( ) Post op nausea or vomiting
( ) Spinal Headache

SURGICAL HISTORY

( ) Appendectomy
( ) Brain Surgery
( ) Breast Surgery
( ) CABG
( ) Cholecystectomy
( ) Cosmetic Surgery
( ) Fracture Surgery
( ) Hernia Repair
( ) Joint Replacement
( ) Ostomy
( ) Prostrate Surgery
( ) Small Bowel Resection
( ) Valve Replacement, Aortic
( ) Vasectomy

FAMILY HISTORY

Please identify what relationship is your family member and if they are <u>paternal</u> or <u>maternal</u>

Alcohol Abuse _____ Arthritis _____ Asthma _____ Birth Defects _____

Cancer _____ COPD _____ Depression _____ Diabetes _____

Drug Abuse _____ Early Death _____ Hearing Loss _____ Heart Disease _____

Hyperlipidemia _____ Kidney Disease _____ Learning Disability _____ Stroke _____

Mental Illness _____ Miscarriage _____ Vision Loss _____ Hypertension _____

Thyroid Problem _____

SOCIAL HISTORY

Do You Smoke Cigarettes? _____ YES _____ NO

Do You Drink Alcohol? _____ YES _____ NO

SYSTEMS REVIEW

General: ( ) Good Health ( ) Declining Health ( ) Fatigue

Endocrine: Endocrinologist _____ ( ) Thyroid Disease
( ) Type I ( ) Type II Date of last eye exam: _____ Date of last foot exam _____

Eyes: Ophthalmologist _____
( ) Glasses/Contacts ( ) Glaucoma ( ) Cataracts ( ) Cataract Surgery ( ) Blurred/Double Vision

Ears, Nose, Mouth & Throat: ENT Doctor _____ ( ) Hearing loss/ringing
( ) Hearing Aide ( ) Chronic Sinusitis ( ) Nose Bleeds ( ) Sore Throat/Voice Change
( ) Earaches/Drainage ( ) Mouth Sores ( ) Bleeding Gums ( ) Bad Breath/Taste ( ) Swollen neck glands

Heart & Vascular: Cardiologist _____
( ) Chest Pain/Angina ( ) Palpitations/Heart Racing ( ) Shortness of Breath ( ) Wake up short of breath
( ) Ankle Swelling ( ) Leg Pain with walking ( ) Foot pain while sleeping

Lungs: Pulmonary Doctor _____
( ) Chronic Cough ( ) Coughing Blood ( ) Difficulty Breathing ( ) Asthma/Wheezing

Genitourinary: Nephrologist/Urologist _____
( ) Burning with urination ( ) Blood in Urine ( ) Difficulty Urinating ( ) Kidney Stones
( ) Impotence ( ) Urinary Incontinence ( ) Testicular Pain ( ) Painful Intercourse ( ) Post Menopause

Musculoskeletal: Orthopedist _____
( ) Arthritis ( ) Muscular Pain/Weakness ( ) Back Pain/Disk Disease ( ) Difficulty Walking

Skin/Breast: Dermatologist _____
( ) Psoriasis ( ) Chronic Rash ( ) Change in Hair/Nails ( ) Varicose Veins ( ) Breast Lump
( ) Breast Pain ( ) Nipple Discharge

Neurological: Neurologist _____
( ) Chronic Headaches ( ) Seizures ( ) Tremors ( ) Stroke ( ) Head Injury

Psychiatric: Psychiatrist _____
( ) Memory Loss/Confusion ( ) Anxiety ( ) Depression ( ) Insomnia

Hematologic/Lymphatic: Oncologist: _____
( ) Anemia ( ) Bleeding Tendencies ( ) Prior Blood Transfusions ( ) AIDS

Allergy: ( ) Food Allergy _____ ( ) Shellfish
( ) Environmental Allergy (hay fever, dogs/cats, pollen, etc.)
Medication: _____