

MEDICAL QUESTIONNAIRE

Name: _____

Who referred you today? _____

Who is your primary care doctor? _____

What is the reason for seeing the doctor today? _____

Please check if you currently or have had any of these conditions:

- Anemia
- Anesthesia related problems
- Back or neck problems
- Bleeding or bruising tendency
- Blood thinners other than Aspirin
- Blood clots in legs
- Blood transfusion reaction
- Cancer
- Chest pain
- Chronic cough
- Chronic pain
- Diabetes
- Heart disease
- Heart surgery
- High blood pressure
- Jaundice or liver disease
- Kidney disease
- Lung disease (Asthma or emphysema)
- Nervous breakdown
- Pacemaker
- Seizures

Do you have any of these problems? (Check all that are applicable)

| | |
|------------------------|--------------------------|
| Rectal bleeding | Rectal pain |
| Change in bowel habits | Abdominal pain or cramps |
| Constipation | Diarrhea |
| Weight loss | Weakness or tiredness |
| Fever | Difficulty in breathing |
| Chest pain | Palpitation |

Social history:

How much alcohol do you drink in a day? _____

Do you smoke? How much? _____

Do you take care of yourself or someone looks after you? _____

Personal history (For Colon & rectal patients only)

Do you use any laxatives?

Do you use any herbal or diet supplements?

Does something protrude or stick out of the rectum?

Do you have accidental leakage of gas, liquid or solid stools?

Do you have any anal discharge or leakage staining your underwear?

Have you ever had a cancer of the colon or rectum?

Have you ever had any operations on your colon or rectum?

Have you ever had a colonoscopy?

Family history:

- Colon cancer
- Colon Polyps
- Ulcerative colitis or Crohn's disease
- Breast, Ovarian or Uterine cancer

List any previous surgery or procedures:

List your current medications:

Allergies:

Are you allergic to Iodine or latex (circle one):