

COLORECTAL HISTORY & PHYSICAL

PLACE PATIENT LABEL HERE

Date: _____

Chief Complaint: _____

How long have you had this complaint? _____

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright Red	Dark Red
If yes, is the blood mixed with the stool or not mixed with the stool?	Mixed	Not Mixed
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No
Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No
Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
In mothers, did you have birthing trauma that required stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No
If yes, what is the location? _____		
Has anyone in your family had colon cancer at age less than 50?	Yes	No
Has anyone in your family had colon polyps?	Yes	No
Has anyone in your family had more than 10 colon polyps?	Yes	No
Do you need antibiotics prior to dental procedures?	Yes	No

Age _____ Height _____ Weight _____

Date of birth: _____ Sex _____ M _____ F



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(cont'd)

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Past Medical History (place an **X** in the box next to your associated medical conditions)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Colon polyps
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Migraines	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Enlarged prostate	<input type="checkbox"/> Uterine cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Abnormal heart rhythm	<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart valve damage	<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Kidney disease

Other: _____

Previous Surgeries: _____

Medications: (please include name, dose, and when taken)

Allergies to Medications: (please list the medication *and* your reaction to this medication)

Social History:

Do you smoke? Yes No Do you drink alcohol? Yes No

How many years? _____ Daily? Yes No

How many packs per day? _____

Do you take aspirin daily? Yes No

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Family History: (please specify which family member had any of the following conditions)

Colon polyps _____	Colon cancer _____
Ulcerative colitis _____	Crohn's disease _____
Familial polyposis _____	Breast cancer _____
Uterine cancer _____	Diabetes _____
Heart disease _____	Strokes _____

Review of Systems

Eyes:

Have your eyes turned yellow?	Yes	No	Do you have glaucoma?	Yes	No
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Head, ears, nose throat and neck:

Do you have loose teeth?	Yes	No	Any frequent nose bleeds?	Yes	No
Any chronic sinus problems?	Yes	No	Do you have sleep apnea?	Yes	No

Cardiac:

Do your legs ever swell up?	Yes	No	Does your heart ever flutter?	Yes	No
Do you have chest pain?	Yes	No	Do you ever get light-headed?	Yes	No

Lungs:

Do you get short of breath?	Yes	No	Do you have a chronic cough?	Yes	No
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Gastrointestinal:

Have you been nauseated recently?	Yes	No	Are you constipated?	Yes	No
Have you been vomiting recently?	Yes	No	Have you been having diarrhea recently?	Yes	No

Genitourinary:

Do you urinate often during the night?	Yes	No	Do you have blood in the urine?	Yes	No
Do you get urinary infections?	Yes	No	Any pain/burning when you urinate?	Yes	No

Neurologic?

Do you have headaches?	Yes	No	Are you sensitive to light?	Yes	No
Any recent slurring of your speech?	Yes	No	Have you ever been temporarily blind?	Yes	No

Integuments:

Any skin ulcers?	Yes	No	Any breast pain or masses?	Yes	No
Dry skin?	Yes	No	Any unusual rashes?	Yes	No

Psychiatric:

Feeling down?	Yes	No	Hearing voices?	Yes	No	Trouble concentrating?	Yes	No
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Endocrine:

Gaining weight?	Yes	No	Losing weight (not intentional)?	Yes	No
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Hematologic:

Bleeding problems?	Yes	No	Prior blood clots?	Yes	No	Sickle cell disease?	Yes	No
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Musculoskeletal:

Difficulty walking	Yes	No	Do your joints hurt?	Yes	No
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Have you had any of the following tests? (If yes give the approximate date.)

Flexible sigmoidoscopy Yes No Date: _____ Colonoscopy Yes No Date _____

If yes, by whom? _____ If yes, by whom? _____

Barium enema Yes No Date: _____ Cat scan of the abdomen Yes No Date: _____