

Health Questionnaire

Name: _____ **Date:** _____
Age: _____ Birthdate _____ Sex: Male / Female Height: _____ Weight: _____

History:

Chief Complaint: (What brings you to the doctor today?)

Do You Have

Regular Bowel movements? Y N # Bowel movements per day ___ Formed ___ Loose ___
Anal or Rectal Bleeding? Y N If yes : Bright red ___ Dark red ___ With pain ___ without pain ___
drip in the bowl ___ just on the tissue ___ or both ___
Anal or rectal pain? Y N
Anal or rectal itching ? Y N
Protrusion of rectal tissue to the outside with bowel movements? Y N Abdominal Pain? Y N
Difficulty controlling bowel movements ? Y N

Drug Allergies?: Y N (if yes please list drug and reaction): _____

Medications (Please list all medication, including over the counter meds & vitamins with dosages):

Do you take any anticoagulants? Y N If yes, please select which one and the dosage:
___ Plavix _____ ___ Coumadin/Warfarin _____ ___ Aspirin _____

Surgical History:

Please list all surgeries/operations: _____

Have you Ever had A?

Recent Barium Enema or Lower GI X-Ray Study? Y N Where _____ When _____
Colonoscopy? Y N Where _____ When _____

Family History:

Has your mother, father, sister, brother, daughter or son had:
Colon/Rectal cancer ___ Colon/Rectal polyps ___ Ulcerative Colitis or Crohn's disease ___

For Women:

How many children have you had? ___ How many vaginal deliveries? ___

Social History:

What is your occupation: _____ full time/ part time/ retired.
Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Use of alcohol: How many drinks: _____ daily/weekly/monthly/never

Use of tobacco of any kind: Never /Currently smoking ___ (pkgs /day)/ Smokeless/ Previously, but quit: _____

