

NAME: _____ DATE OF BIRTH: _____

Reason for Visit: _____

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Rectal Bleeding _____ | <input type="checkbox"/> Protrusion/Swelling _____ |
| <input type="checkbox"/> Rectal Pain _____ | <input type="checkbox"/> Fecal Incontinence _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Discharge _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Abdominal Pain _____ |
| <input type="checkbox"/> Itching/Burning _____ | <input type="checkbox"/> Irritable Bowel Syndrome _____ |
| <input type="checkbox"/> Change in Bowel Habits _____ | * How often do you move your bowels _____ |
| <input type="checkbox"/> Colonoscopy _____ When _____ | Doctor _____ |

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

- | | |
|--|---|
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Colon Polyps _____ | <input type="checkbox"/> Liver Disease/Hepatitis _____ |
| <input type="checkbox"/> Diverticulosis _____ | <input type="checkbox"/> Stomach Ulcer _____ |
| <input type="checkbox"/> Diverticulitis _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Ulcerative Colitis _____ | <input type="checkbox"/> Phlebitis _____ |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Anal or Rectal Surgery _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Heart Disease (Angioplasty, MI, etc.) _____ | <input type="checkbox"/> Bleed Easily _____ |
| <input type="checkbox"/> Heart Valve Disease _____ | <input type="checkbox"/> Psychiatric _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Bladder Problem _____ |
| <input type="checkbox"/> Heart Murmur: _____ | <input type="checkbox"/> Prostate Problems _____ |
| <input type="checkbox"/> Pace Maker _____ | <input type="checkbox"/> Gynecological Problems _____ |
| <input type="checkbox"/> Defibrillator _____ | <input type="checkbox"/> Musculoskeletal/Prosthetic Joints: _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Vision/Hearing Problems _____ |
| <input type="checkbox"/> Sleep Apnea _____ | <input type="checkbox"/> Personal History of Cancer _____ |
| <input type="checkbox"/> Seizure Disease _____ | <input type="checkbox"/> Any Chance of Pregnancy? _____ |
| <input type="checkbox"/> Neurological Disease: _____ | <input type="checkbox"/> Date Last Menstrual Period: _____ |

FAMILY HISTORY / RELATIONSHIP-IE: MOTHER, FATHER ETC. (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Colon or Rectal Cancer _____ | <input type="checkbox"/> Crohn's Disease _____ |
| <input type="checkbox"/> Colon or Rectal Polyps _____ | <input type="checkbox"/> Ulcerative Colitis _____ |
| <input type="checkbox"/> Other Cancer(s), Type _____ | |

SOCIAL HISTORY

Do you smoke? Yes ___ No ___ Packs Per Day _____ Do you drink alcohol? Yes ___ No ___ Drinks Per Day _____

CURRENT MEDICATIONS (Prescription / Over The Counter / Vitamins / Nutritional Supplements)

Do you take antibiotics prior to surgical or dental procedures? YES ___ NO ___

LIST ALLERGIES (Medications / X-Ray Dye / Latex / Local Anesthesia, Etc.)

SURGICAL HISTORY (List all operations and year performed)

HOSPITALIZATIONS (List all not shown above)

Prior Anesthesia Difficulties: Yes No

Blood Relatives w/Anesthesia Difficulties: Yes No

PAIN ASSESSMENT

If you have pain, describe **location of pain** and using the scale below, please indicate your **level of pain** at this time:

LOCATION OF PAIN

NONE (0)



0

Great, no hurt

MILD (1-3)



2

Hurts just a little



4

Hurts a little more

MODERATE (4-6)



6

Hurts even more



8

Hurts a whole lot

SEVERE (7-10)



10

Hurts as much as you can imagine (don't have to be crying to feel this much pain)

PATIENT SIGNATURE

DATE

****FOR NURSES/PHYSICIANS ONLY****

VITAL SIGNS

B/P _____ Pulse _____ Height _____ Weight _____

****FOR PHYSICIAN ONLY****

EDUCATIONAL NEEDS ASSESSMENT

Any Barriers to Learning? NO YES

- Language
- Cultural
- Cognitive
- Behavioral
- Post Procedure Care

If YES, Areas of Need: Check applicable:

- Medication Reaction
- Pre-Op / Post Op Instruction
- Medication Reaction
- Informed Consent
- Other: _____

Education Provided To:

- Patient
- Spouse
- Home Care Nurse
- Other: _____

PHYSICIAN'S SIGNATURE

DATE