COLON & RECTAL SURGERY

Patient Name ___________________________________ Date: _______________________

Family Medical History

	Age /Alive	Age/ Deceased	Medical Problems/ Cause of Death
Mother	_____	________	______________________________
Father	_____	________	______________________________

Please list how many sisters, brother, or children and their medical problems if any

Sister's	_____	____
Brother's	_____	____
Children	_____	____
Children	_____	____

Allergies

Do you have any allergies to medications, testing dye or latex (as in gloves)? Please circle Yes or No

Name of Medication

______________________ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash

______________________ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash

______________________ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash

Check if any family members have:

___ Colon Cancer
___ Colon Polyps or Tumors
___ Ulcerative Colitis
___ Crohn's Disease
___ Irritable Bowel

___ Breast Cancer
___ Ovarian Cancer
___ Uterine Cancer
___ Other types of G.I. Cancer
___ Other type of Cancer

___ Diabetes
___ Heart Trouble
___ High Blood Pressure
___ Stroke

Your Medical History

List all medical conditions you are or have been treated for:

____

____

____

____

COLON & RECTAL SURGERY

Do you have:

____ Mitral or Aortic Valve Replacement
____ Hip, Knee or Shoulder replacement
____ Cardiac Stents

____ Heart Pacemaker (please provide card)
____ Implanted Defibrillator (please provide card)

List all surgeries or operations you have ever had and the year:

____
____
____

Date of procedure:

____ Colonoscopy
____ Flexible Sigmoidoscopy

____ CT Scan Abdominal/Pelvis
____ Barium Enema

____ Upper GI Series
____ Chest X- Ray

Have you ever had:

___Diabetes
___Heart Trouble
___High Blood Pressure
___Stroke
___Colon Cancer
___Colon Polyps or Tumors
___Ulcerative Colitis
___Crohn's Disease
___Seizures

___Irritable Bowel
___Diverticulitis
___Diverticulosis
___Blood in Stool
___Abdominal Pain
___Constipation
___Diarrhea
___Rectal Bleeding
___Blood Clot, Legs

Other types of cancer
Where: ________________
____
____
____

MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN AND OTHER OVER THE COUNTER DRUGS:

Medication	Dose	What are you taking medication it for?
______________________	_____________	__________________________________
______________________	_____________	__________________________________
______________________	_____________	__________________________________
______________________	_____________	__________________________________
______________________	_____________	__________________________________
______________________	_____________	___________________________________

Pharmacy- Name and location ____