FORT WORTH
COLON & RECTAL
SURGERY ASSOCIATES
Texas Health Care, P.L.L.C.

Patient History-For Dr. Allen's Patients Only

Patient Name:_____ **Date:**_____
Date of Birth:_____/_____/_____ **Age:**_____ **Height:**_____ **Weight:**_____ **Sex: M F**
Chief Complaint:_____
How long have you had this complaint?_____

Current Conditions: Circle the appropriate answers for each question

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
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

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Patient Name:_____ **Date:**_____

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

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

Previous Surgeries (include dates): _____

_____

_____

_____

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

_____ _____

_____ _____

_____ _____

Any Allergies? (please list the medication or substance *and* your reaction):

_____

_____

Are you allergic to latex? Yes No Are you allergic to peanuts? Yes No

Social History:

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

Have you ever smoked? Yes No Daily? Yes No

How many years? _____ Do you use caffeine? Yes No

How many packs per day? _____ Type/quantity/frequency _____

Do you take aspirin daily? Yes No

Do you take blood thinners? (i.e. Coumadin, Plavix, Xarelto, Pradaxa, Eliquis) Yes No

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_____

Diabetes_____ Uterine cancer_____

Heart disease_____ Other cancer _____

Stroke _____ Other _____

Patient Name:_____ **Date:**_____

Review of Systems:

Eyes:

Have your eyes turned yellow?	Yes	No
Do you have glaucoma?	Yes	No

Head, ears, nose, throat and neck:

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

Cardiac:

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

Gastrointestinal:

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

Genitourinary:

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

Neurologic:

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

Integuments:

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

Psychiatric:

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

Endocrine:

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

Hematologic:

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

Musculoskeletal:

Difficulty walking?	Yes	No
Do your joints hurt?	Yes	No

Have you had any of the following tests? (If yes give the approximate date.)

Flexible sigmoidoscopy Yes No Date: _____ If yes, by whom? _____
Colonoscopy Yes No Date(s)_____ If yes, by whom/where?_____
If yes, were polyps found? Yes No How many colonoscopies have you had? _____
Barium enema Yes No Date: _____
CT scan of the abdomen Yes No Date: _____

Which pharmacy do you use? _____
Address: _____Phone number: _____