FORT WORTH COLON & RECTAL SURGERY ASSOCIATES

Texas Health Care, P.L.L.C.

Patient History-For Dr. Senter's Patients Only

Patient Name:_________________________ **Date:**______________

Date of Birth:_____/_____/_______ **Age:**______ **Height:**_______ **Weight:**_________ **Sex:** M F

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 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? ______________________		
Have you experienced any recent unintentional weight loss?	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
Do you need antibiotics prior to dental procedures?	Yes	No

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
	Rheumatic Fever		Enlarged prostate		Uterine cancer
	Liver disease		Abnormal heart rhythm		Prostate cancer
	Hepatitis		Heart valve damage		Blood clots
	Diverticulitis		Heart murmur		Stroke
	Fibromyalgia		Heart attack		Kidney disease
	Glaucoma		Anemia		Other______________

Patient Name:______________________________ **Date:**______________

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

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: ____________

Social History:

Do you smoke? Yes No

Have you ever smoked? Yes No

How many years? ______

How many packs per day? ______

Do you drink alcohol? Yes No

Daily? Yes No

Do you use caffeine? Yes No

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____________________

Ulcerative colitis____________________

Familial polyposis____________________

Diabetes____________________

Heart disease____________________

Stroke ____________________

Colon cancer____________________

Crohn's disease____________________

Breast cancer____________________

Uterine cancer____________________

Other cancer ____________________

Other ____________________

Which pharmacy do you use? ______________________________

Address: ______________________________Phone number: ________________