CENTER OF COLON AND RECTAL SURGERY
Cesare Peraglie MD FACS FASCRS

NAME: _____ **DATE:** _____

COLON AND RECTAL SYMPTOMS

O Fever/Chills O Change in Bowels O Blood in Stool O Mucos Discharge
O Nausea O Constipation O Rectal Pain O Urgency/Tenesmus
O Vomiting O Diarrhea O Protrussion/Swelling O Cramps
O Abdominal Pain O Incontinence O Anal Itch/Burn O Straining/Pushing
O Need for laxative/enema use

MEDICAL HISTORY (Please check [x] all medical conditions you have or have had in the past)

____AIDS ____Alcoholism ____ Anemia ____ Asthma
____Arthritis ____Bleeding Disorder ____ Breast Mass ____ Bronchitis
____Bulimia ____Cancer ____ Colon Cancer____ Colon Polyps
____Crohns Disease ____Diabetes ____ Deep Vein Thrombosis
____Emphysema ____Epilepsy ____ Goiter ____ Gonorrhea
____Gout ____Heart Disease ____ Hepatitis ____ Herpes
____Hypertension ____Cholesterol ____ HIV positive ____ Kidney Disease
____Liver Disease ____Headaches ____ Multiple Sclerosis
____Pacemaker ____Pneumonia ____ Prostate Problems
____Psychiatric ____Pulomonary Embolism
____Rheumatic Fever ____Reaction to Anesthesia
____ Suicide Attempt ____ Stroke ____ Thyroid Problems
____ Tuberculosis ____ Stomach Ulcers ____ Vaginal Infections
____ Venereal Disease_____
O Other_____

MEDICATIONS

DRUG NAME	DOSAGE	TAKEN HOW OFTEN	WHY TAKEN	HOW LONG TAKEN

DRUG ALLERGIES AND REACTION (Meds, latex etc…)

1)_____

2)_____

3)_____

4)_____

5)_____

SURGICAL HISTORY (Please list all surgical procedures you have had in the past)

Have you had a_Colonoscopy/Flex-sig_____Year:_____

1)_____ Year:_____

2)_____ Year:_____

3)_____ Year:_____

4)_____ Year:_____

5)_____ Year:_____

OBSTETRICAL HISTORY

Nmber of Deliveries:_____ Any Tears:_____

Prolonged labor:_____ Breech Birth:_____

Forceps Delivery:_____

SOCIAL HISTORY

Do You Drink Alcohol:_____ How much/How Often:_____

Do you Smoke:_____ How Much/How Long:_____

Drug Use:_____

Sexually Active:_____ Heterosexual/ Homosexual

Any ano-receptive sexual practices:_____

FAMILY MEDICAL HISTORY (Please check [x] all medical conditions your blood relatives have, indi
relationship)

____ AIDS	____ Alcoholism	____ Arthritis	____ Asthma
____ Bleeding	____ Breast Disease	____ Cancer	____ Clotting Disorde
____ Colitis	____ Colon Cancer	____ Colon Polyps	____ Crohn's
____ Depression	____ Diabetes	____ Emphysema	____ Heart Attack
____ Heart Disease	____ Hepatitis	____ Hypertension	____ Kidney Disease
____ Liver Disease	____ Stroke		

Other_____

REVIEW OF SYSTEMS: (Please Check any that you have)

General/Constitution

_____Fever _____Fatigue
_____Weight Gain/Loss _____Loss of Appetite
_____Bleeding Gums _____Mouth Sores
_____Frequent Sore Throat _____Hoarseness
_____Difficulty Swallowing _____Weakness

Cardiovascular

_____Chest Pain at rest or with activity
_____Shortness of breath at rest/with activity
_____Leg Swelling _____Irregular Heart Beat
_____Heart Palpitations

Respiratory

_____Chronic Cough _____Coughing Up Blood
_____Pneumonias _____Wheezing
_____Asthma _____Night Sweats

Gastrointestinal

_____Vomiting Blood _____Heartburn
_____Regurgitation _____Difficult Swallowing
_____Pain with Swallowing _____Yellow Jaundice

Genitourinary

_____Difficult Urination _____Painful Urination _____Blood in Urine
_____Frequent Urination _____Urgency _____Kidney Stones
_____Erection difficulties _____Prostate troubles
_____Frequent Night Urination
_____Discharge from penis/vagina

Neurological

_____Headaches _____Dizziness _____Fainting
_____Convulsions _____Arm / Leg Weakness _____Memory Loss
_____Sensitivity of hands / feet

Psychiatric

_____Depression _____Suicide Attempt _____Panic Attacks
_____Psych. Counseling

Endocrine

_____Flushing _____Increased Thirst _____Increased salt intake
_____Finger nail changes _____Heat/cold intolerance

Hematologic

_____Anemia _____Bleeding Tendency _____Prone to Clotting