

**COLON RECTAL HEALTH CENTER****CHIEF COMPLAINT:** \_\_\_\_\_**HISTORY OF THE PRESENT ILLNESS:**Describe the **signs/symptoms** that you have: \_\_\_\_\_

When did the signs start?: \_\_\_\_\_

Are you experiencing pain?  Yes  No If yes, how would you rate your pain on a scale of 1 to 10, 10 being the worst?Please check: 1.  2.  3.  4.  5.  6.  7.  8.  9.  10. Describe your pain:  Comes and goes  Constant  Other (Describe) \_\_\_\_\_

Please click in the box that applies what you are experiencing:

**Daily bowel movements**

- |  |
|--|
| <input type="checkbox"/> More than one movement per day                          |
| <input type="checkbox"/> Hard bowel movements                                    |
| <input type="checkbox"/> Loose bowel movements                                   |
| <input type="checkbox"/> Pain with bowel movements                               |
| <input type="checkbox"/> Abdominal pain  |
| <input type="checkbox"/> Protusion of rectal tissue:                             |
| <input type="checkbox"/> constantly <input type="checkbox"/> with bowel movement |

**Rectal bleeding**

- |   |
|---|
| <input type="checkbox"/> Bright red       |
| <input type="checkbox"/> Dark red         |
| <input type="checkbox"/> On toilet paper  |
| <input type="checkbox"/> Dripping in bowl |
| <input type="checkbox"/> Outside of stool |
| <input type="checkbox"/> Mixed in stool   |
| <input type="checkbox"/> Rectal drainage  |

**General**

- |  |
|--|
| <input type="checkbox"/> Nausea / Vomiting       |
| <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Impacted                |
| <input type="checkbox"/> Acid Reflux / Heartburn |
| <input type="checkbox"/> Rectal itching          |
| <input type="checkbox"/> Loss of appetite        |

**MEDICAL HISTORY:**Are you HIV positive? Yes  No  Don't know 

Have you had:	Date:	Results:	Date:	Results:
<input type="checkbox"/> Barium Enema	_____	_____	<input type="checkbox"/> Colonoscopy	_____
<input type="checkbox"/> Lower GI Study	_____	_____	<input type="checkbox"/> Sigmoidoscopy	_____

Family History: Colon Cancer: Yes  No  Polyps: Yes  No **Do you have any allergies to:**  Food  Medication(s)  Latex  Iodine  No allergiesPlease list **allergies** to medication and reactions:

_____ / _____	_____ / _____
_____ / _____	_____ / _____

**MEDICATIONS:**

List all current medications, including prescription, supplements and over the counter drugs:

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\_\_\_\_\_  
Patient Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Legal guardian if other than patient\_\_\_\_\_  
Date