

COLON RECTAL HEALTH CENTER

PATIENT MEDICAL HISTORY

PLEASE PRINT:

HISTORY OF SURGERY(S) OR HOSPITALIZATIONS:

MEDICAL HISTORY:

Have you, or any members of your family had any of the following? Please put an "X" in the box that applies:

SELF / FAMILY MEMBER

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- | | | |
|----------------------------------------------|-----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hay Fever / Sinus Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding / Bruising | <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug / Alcohol Dependency | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> +A1 Arthritis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Skin Disease |

PATIENT SOCIAL HISTORY:

Alcohol Use: Never Rarely Moderate Daily Amount? ____/day

Tobacco Use: Never Occasionally Previously, but quit (Date) _____

Substance Abuse: Never Yes Type / Frequency _____

Environmental Exposure: Dust Fumes Solvents List all: _____

Patient Signature

Date

Legal guardian if other than patient

Date