

Kennebec Medical Consultants**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:

Patient Signature_____
Date_____
Legal guardian if other than patient_____
Date