# COLON RECTAL HEALTH CENTER

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# PATIENT MEDICAL HISTORY

PLEASE PRINT

**HISTORY OF SURGERY(S) OR HOSPITALIZATIONS** (PROCEDURE & YEAR):

_____ _____

_____ _____

_____ _____

**EXISTING MEDICAL CONDITIONS:**

_____

_____

**MEDICAL HISTORY:**

HAVE YOU, OR ANY MEMBERS OF YOUR FAMILY HAD ANY OF THE FOLLOWING? PLEASE PUT AN "X" IN ALL THAT APPLIES:

| SELF / FAMILY MEMBER | | SELF / FAMILY MEMBER | | SELF / FAMILY MEMBER | |
|---|---|---|---|---|---|
| ☐ | ☐ ANEMIA | ☐ | ☐ EPILEPSY/SEIZURES | ☐ | ☐ HEART PROBLEMS |
| ☐ | ☐ BLOOD DISORDER | ☐ | ☐ HAY FEVER / SINUS PROBLEMS | ☐ | ☐ HIGH BLOOD PRESSURE |
| ☐ | ☐ HEPATITIS | ☐ | ☐ HIGH CHOLESTEROL | ☐ | ☐ STROKE |
| ☐ | ☐ BLEEDING/BRUISING | ☐ | ☐ DEPRESSION | ☐ | ☐ LUNG DISEASE |
| ☐ | ☐ DIABETES | ☐ | ☐ EMOTIONAL PROBLEMS | ☐ | ☐ THYROID DISEASE |
| ☐ | ☐ ASTHMA | ☐ | ☐ DRUG/ALCOHOL DEPENDENCY | ☐ | ☐ KIDNEY DISEASE |
| ☐ | ☐ BRONCHITIS | ☐ | ☐ ARTHRITIS | ☐ | ☐ LIVER DISEASE |
| ☐ | ☐ EMPHYSEMA | ☐ | ☐ IMMUNE DISORDERS | ☐ | ☐ SKIN DISEASE |

**PATIENT SOCIAL HISTORY:**

ALCOHOL USE: ☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY AMOUNT? _____/DAY

TOBACCO USE: ☐ NEVER ☐ OCCASIONALLY ☐ PREVIOUSLY 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

_____ _____

Physician Signature Date