Colorectal Health Northwest

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HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Daytime Phone: _____ Alternate Phone: _____

Reason for visit: _____

Primary Care Physician Name and Phone:	Referring Physician Name and Phone:

MEDICATION (Please list ALL medications that you are currently taking and their doses. Please include over the counter medications, vitamins and supplements)

Name of Medication	Strength	Name of Medication	Strength

DRUG ALLERGIES: Do you have any allergies to medications? ☐ NO ☐ YES, please list medications and reactions below

_____

_____

PHARMACY

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PAST MEDICAL HISTORY: (Please list any illnesses or medical problems you have had, and the approximate date of their occurrence)

_____

_____

_____

_____

PAST SURGICAL HISTORY: (Please list all operations you have had and the dates of their occurrence)

_____

_____

PREVIOUS COLON CANCER SCREENING: (Please list the most recent colon screenings you have undergone and the dates of their occurrence)

☐ Flexible Sigmoidoscopy: (Year & Physician) _____ ☐ Barium Enema: _____

☐ Colonoscopy: (Year & Physician) _____ ☐ Other: _____

FAMILY HISTORY (Please list you family member and the disease associated)

☐ Colon or Rectal Cancer: _____ ☐ Colon or Rectal Polyps: _____

☐ Ulcerative Colitis: _____ ☐ Crohn's Disease: _____

☐ Other: _____

SOCIAL HISTORY

What is your marital status? ☐ Single ☐ Married ☐ Widowed ☐ Other _____

Occupation: ☐ Retired ☐ Unemployed ☐ Employed/Job: _____

Employer: _____

Do you have children? ☐ YES ☐ NO How many _____

Would you like a chaperone during your visit? ☐ YES ☐ NO

Do you have any religious objection to blood transfusion? ☐ YES ☐ NO _____

Do you currently smoke cigarettes? ☐ YES ☐ NO Packs/day _____

Have you ever smoked cigarettes? ☐ YES ☐ NO Year you quit _____

Do you currently use any drugs, including marijuana? ☐ YES ☐ NO Type _____

Do you drink alcohol? ☐ YES ☐ NO Type & drinks/week _____

REVIEW OF SYSTEMS (Do you currently have or have had a history of the following? Please check all that apply)

GENERAL
- ☐ Recurrent fever
- ☐ Significant weight change
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Malaise
- ☐ Sleep disorder

EYES, EARS, NOSE & THROAT
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Eye pain
- ☐ Tinnitus
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness

CARDIOVASCULAR
- ☐ Abnormal heart valve
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Peripheral edema
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Pacemaker

RESPIRATORY
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Productive cough
- ☐ Sleep apnea/CPAP

ABDOMINAL/GI
- ☐ Hernia
- ☐ Peptic ulcer
- ☐ Difficulty swallowing
- ☐ Reflux
- ☐ Jaundice
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Gas/bloating
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Constipation
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Bloody BMs
- ☐ Black BMs
- ☐ Fecal incontinence

UROLOGIC/REPRODUCTIVE
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Urinary hesitancy
- ☐ Nocturnal urination
- ☐ Prostate problems
- ☐ Vaginal discharge

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Arthritis
- ☐ Shoulder pain/hand/wrist
- ☐ Low back pain
- ☐ Muscle weakness
- ☐ Leg pain with exertion

DERMATOLOGIC
- ☐ Rash
- ☐ Itching
- ☐ Hives
- ☐ Skin cancer
- ☐ Non-healing ulcers

NEUROLOGIC
- ☐ Seizure
- ☐ Fainting/blackouts
- ☐ Stroke
- ☐ Paralysis
- ☐ Tremors
- ☐ Frequent headaches
- ☐ Difficulty walking
- ☐ Sciatica
- ☐ Confusion
- ☐ Memory loss

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Steroid use

HEMATOLOGIC
- ☐ Bruising
- ☐ Bleeding
- ☐ Blood thinner use

ONCOLOGIC
- ☐ Radiation
- ☐ Chemotherapy

☐ Other: _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Entered into EMR by: _____ Date: _____

I have reviewed the above information with the patient on this date.

Physician's Signature: _____ Date: _____