Colon & Rectal Surgery

New Patient Information

THE POLYCLINIC

Patient Name:_____ Age:_____

Occupation:_____ # of children:_____ Marital Status:_____

Primary Care Physician _____ Referring Physician _____ Report to whom? _____

Reason(s) for visit:

_____

Allergies (including latex) :_____ Preferred Pharmacy:_____

Please list all medications that you use. (prescription, over the counter, aspirin, laxatives, fiber additives)

_____

_____

_____

	Date	Hospital/MD
Past Surgery		
Serious Illness/Hospitalization		
Previous Pregnancy/Delivery		
Most recent Colonoscopy		

If you have a family member with any of the following cancers or conditions, please list relationship and age at diagnosis:

	Y/N	Who?	Age		Y/N	Who?	Age
Numerous Colon Polyps				Colon or Rectal cancer			
Hemorrhoids				Small bowel cancer			
Colitis				Stomach cancer			
Pancreas cancer				Urinary Tract cancer			
Bile Duct cancer				Uterine cancer			
Brain cancer				Ovarian cancer			

Please Turn Over & Complete Both Sides

Please complete concerning YOUR OWN past medical history in the categories below:

Yes	No	Condition	Explain/Other
		HIV/AIDS	
		Bleeding disorder	
		Cancer	
		Cardiac	
		Heart attack / Coronary artery disease	
		Heart valves	
		Peripheral vascular disease	
		High blood pressure	
		Gastrointestinal	
		Liver, Hepatitis	
		Urinary/ Kidney	
		Gynecologic	
		Endocrine	
		Diabetes	
		Thyroid/parathyroid	
		Joint/skin disease	
		Neurological	
		Seizures	
		Stroke	
		Headaches	
		Pulmonary	
		Asthma	
		Emphysema	
		Psychiatric	
		Depression	
		Anxiety	
		Tobacco Use	Amount-
		Drug Use	Amount-
		Alcohol	Amount-