



# SAN DIEGO COLON AND RECTAL SURGEONS

Colon & Rectal • Laparoscopic Surgery

9834 Genesee Avenue • Suite 201 • La Jolla, California 92037 • Tel: 858.558.2272 • Fax: 858.558.2285 • www.sdcolonrectal.com

## HISTORY & PHYSICAL

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Referred by: \_\_\_\_\_

For Doctor's use only

BP	Pulse	Weight	Height

*We sincerely appreciate your taking the time to complete the following questions about your personal medical history before seeing the doctor. This information will be of significant importance in providing for your personal health care.*

### CHIEF COMPLAINT

*List the problems which have led you to seek medical help now, and approximately when each began.*

	PROBLEM	DATE OF ONSET
1.		
2.		

### PAST MEDICAL AND SURGICAL HISTORY (Attach separate sheet if necessary)

*List chronologically the surgery you have had, indicating the nature of each operation and where and when it was done.*

OPERATION	HOSPITAL & CITY	DATE

Have you ever been seriously injured? (If so, give details) \_\_\_\_\_

*List all medical problems for which you see or have seen a doctor (most significant first).*

MEDICAL PROBLEM	DOCTOR SEEN	DATE

*List chronologically all hospitalizations not already mentioned.*

REASON FOR HOSPITALIZATION	HOSPITAL & CITY	DATE

Have you ever had any of the following? (If so, give date and details)

- Heart Attack \_\_\_\_\_
- Palpitations \_\_\_\_\_
- Chest Pain (Angina) \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Lung Disease/Pneumonia \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Asthma \_\_\_\_\_
- Intestinal Bleeding \_\_\_\_\_
- AIDS/HIV Infection \_\_\_\_\_

- Cancer \_\_\_\_\_
- Prolonged Bleeding \_\_\_\_\_
- Hepatitis/Jaundice \_\_\_\_\_
- Alcoholism \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Stroke \_\_\_\_\_
- Arthritis/Gout \_\_\_\_\_
- Other Illness \_\_\_\_\_
- Nervous Breakdown \_\_\_\_\_

**(OVER)**

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

**CURRENT MEDICATIONS**

List all the medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate and complete. (Do NOT neglect aspirin and other pain medicines, hormones; contraceptive, water, diet, nerve, sleeping, iron or vitamin pills). Include list of non-prescription medications (ask for additional sheet if needed).

CURRENT MEDICINE	STRENGTH OF DOSE	HOW OFTEN TAKEN	START DATE

**MEDICATION ALLERGIES**

NAME OF MEDICATION	YES	NO	TYPE OF REACTION AND WHEN
Penicillin			
Sulfa			
Iodine			
Other			

**HABITS**

**TOBACCO**

Do you smoke now? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_ How many cigarettes per day? \_\_\_\_\_

If you do not smoke now, did you smoke in the past? \_\_\_\_\_

If so, when did you Start? \_\_\_\_\_ Stop? \_\_\_\_\_ How many cigarettes per day? \_\_\_\_\_

per day? \_\_\_\_\_

**ALCOHOL**

How many alcoholic beverages do you drink per day? \_\_\_\_\_

**CAFFEINE**

**PERSONAL HISTORY**

Where were you born? \_\_\_\_\_ How long have you lived in California? \_\_\_\_\_

Have you lived or travelled outside the U.S.? \_\_\_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

What type of work do you do on a daily basis (e.g. desk work, house cleaning, gardening, heavy manual labor, etc.)? \_\_\_\_\_

Are you married?: \_\_\_\_\_ For how long? \_\_\_\_\_ Have you any children? \_\_\_\_\_ How many? \_\_\_\_\_

**FAMILY HEALTH**

Please give the following information about the health of your immediate family:

RELATION	Age	Age at Death	STATE OF HEALTH OR CAUSE OF DEATH	Colon Cancer or Polyps
MOTHER				
FATHER				
BROTHERS				
AND				
SISTERS				
SPOUSE				
CHILDREN				

Have any blood relatives ever had any of the following? (If so, indicate relationship).

Diabetes: \_\_\_\_\_ Cancer: \_\_\_\_\_ High blood pressure: \_\_\_\_\_  
 Rheumatoid arthritis: \_\_\_\_\_ Blood disease: \_\_\_\_\_ Any obscure or unusual disease: \_\_\_\_\_  
 Tuberculosis: \_\_\_\_\_ Allergies: \_\_\_\_\_ Psychiatric disease or nervous breakdown: \_\_\_\_\_  
 Gout: \_\_\_\_\_ Alcoholism: \_\_\_\_\_ A disease which "runs in the family": \_\_\_\_\_  
 Lung Disease: \_\_\_\_\_ Asthma: \_\_\_\_\_ Hay fever: \_\_\_\_\_