Sacramento Colon and Rectal Surgery Medical Group
New Patient Questionnaire

Name: _____ **Age** _____ **Date of Visit** _____

Chief Complaint / History of Present Illness (If using the computer press the **Tab key** to go to the next field)

What problem brought you here? _____

_____

When did your symptoms start? _____

_____

Rectal Bleeding? ☐ Yes ☐ No
Frequency: ☐ Rare ☐ Occasional ☐ Frequent
Location: ☐ Toilet bowl ☐ Tissue ☐ Both
Associated with bowel movements? ☐ Yes ☐ No

Rectal Pain?
Frequency: ☐ Rare ☐ Occasional ☐ Frequent
Character: ☐ Sharp ☐ Throbbing ☐ Burning
☐ Itching ☐ Discomfort
Associated with bowel movements? ☐ Yes ☐ No
Associated with a lump or swelling? ☐ Yes ☐ No

Prolapse (hemorrhoids come out)? ☐ Yes ☐ No
If yes, do you push them back in? ☐ Yes ☐ No

Discharge (mucus or pus from the anus)? ☐ Yes ☐ No

Incontinence (leakage from the anus)? ☐ Yes ☐ No
For What? ☐ Gas ☐ Liquid stool ☐ Solid stool
When? ☐ Always ☐ Occasional ☐ At night
Do you wear a pad? ☐ Yes ☐ No

What is your normal stool pattern?
☐ Less than one stool every other day
☐ One to two stools a day or every other day
☐ More than three stools a day

What is the usual character of your stool?
☐ Hard ☐ Formed ☐ Soft ☐ Liquid

Have you noted a recent change in your stool patterns?
☐ Yes ☐ No

Do you have a problem with intermittent diarrhea? ☐ Yes ☐ No
Is stress related? ☐ Yes ☐ No

Do you have abdominal pains or cramps? ☐ Yes ☐ No

Are they relieved by passing stool or gas? ☐ Yes ☐ No

Have you experienced any weight loss? ☐ Yes ☐ No

Family History (If yes, list below)

Has anyone in your family had colon cancer? ☐ Yes ☐ No ☐ Don't Know

Has anyone in your family had colon polyps? ☐ Yes ☐ No ☐ Don't Know

Is there any history of ovarian/uterine cancer? ☐ Yes ☐ No ☐ Don't Know

Family history of any other disease? ☐ Yes ☐ No ☐ Don't Know

If Yes:

	Disease		Disease
1. Father		**4. Sisters**	
2. Mother		**5. Children**	
3. Brothers		**6. Others**	

Social & Personal History

What is your Occupation? _____

Retired: ☐ Yes ☐ No

☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

Do you smoke? ☐ Yes ☐ No ☐ Quit # Packs/day _____

Do you use alcohol? ☐ Yes ☐ No ☐ Quit Drinks per day? _____

Do you or have you ever used recreational drugs?

☐ Yes ☐ Never ☐ Quit Type: _____

Caffeine? ☐ Yes ☐ No Cups per day? _____

Exercise? ☐ Never ☐ Rare ☐ Occasional ☐ Regular

Past Medical / Surgical History

Have you had any difficulty with anesthesia in the past?

☐ Yes ☐ No

Have you had any problems with bleeding during or after surgery in the past?

☐ Yes ☐ No

If yes, explain: _____

Have you had any previous rectal surgery? ☐ Yes ☐ No

If yes, what type: _____ When? _____

Have you had a barium enema? (colon x-rays?) ☐ Yes ☐ No When? _____

Have you had a flexible sigmoidoscopy? ☐ Yes ☐ No When? _____

Have you had a colonoscopy? ☐ Yes ☐ No When? _____

Please list any medical problems (e.g. diabetes, high blood pressure, cancer, etc): ☐ None

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list ALL previous operations or procedures:(Additional space at the end) ☐ None

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List any Complications: ☐ None

_____

_____

List ALL medications and dosages you are currently taking: ☐ None

Please include non-prescription drugs, aspirin, Motrin and other arthritis pain medications.(Additional space at the end)

Name/Dose/Frequency	Name/Dose/Frequency
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Are you allergic to any medications, pills, food, etc.? (Please list below:) ☐ None

_____

_____

Review of Systems (Please indicate if you **currently have or have ever had** any of the following:)

		Yes	No	Recent
GENERAL:	Fever / Chills	☐	☐	☐
	Recent weight change	☐	☐	☐
SKIN:	Rashes / Itching	☐	☐	☐
	Hair loss	☐	☐	☐
	Changes in moles	☐	☐	☐
HEENT:	Blurred or double vision	☐	☐	☐
	Dizziness	☐	☐	☐
	Difficulty hearing	☐	☐	☐
	Nose bleeds	☐	☐	☐
CARDIO:	High blood pressure	☐	☐	☐
	Chest pain/angina	☐	☐	☐
	Irregular heart beat	☐	☐	☐
	Heart attack	☐	☐	☐
	Cardiac catheterization	☐	☐	☐
	Vascular disease	☐	☐	☐
	Leg swelling	☐	☐	☐
PULMONARY:	Shortness of breath	☐	☐	☐
	Sleep Apnea	☐	☐	☐
	Do you use a CPAP mask	☐	☐	☐
	Pneumonia	☐	☐	☐
	Coughing blood	☐	☐	☐
	Tuberculosis (TB)	☐	☐	☐
	Blood clots in the lung	☐	☐	☐
	Deep vein thrombosis	☐	☐	☐
	Lung disease / COPD	☐	☐	☐
	Asthma	☐	☐	☐
BREASTS:	Lumps	☐	☐	☐
	Breast Cancer	☐	☐	☐
	Last mammogram:	_____		
GI:	Nausea / Vomiting	☐	☐	☐
	Diarrhea	☐	☐	☐
	Bloody stool or black stool	☐	☐	☐
	Constipation	☐	☐	☐
	Hepatitis	☐	☐	☐
	Reflux	☐	☐	☐
	Stomach ulcers	☐	☐	☐
	Hernia	☐	☐	☐

		Yes	No	Recent
GU:	Urinary frequency	☐	☐	☐
	Urgency	☐	☐	☐
	Incontinence	☐	☐	☐
	Painful urination	☐	☐	☐
	Blood in urine	☐	☐	☐
	Kidney stones	☐	☐	☐
	Prostate disease	☐	☐	☐
GYN:	Last menstrual period:	_____		
	Last pap smear:	_____		
MS:	Joint pain	☐	☐	☐
	Back pain	☐	☐	☐
	Arthritis	☐	☐	☐
	Arm numbness / weakness	☐	☐	☐
	Leg numbness / weakness	☐	☐	☐
NEURO:	Stroke	☐	☐	☐
	Seizures	☐	☐	☐
	Tremors	☐	☐	☐
PSYCHE:	Depression	☐	☐	☐
	Anxiety	☐	☐	☐
ENDOCRINE:	Diabetes	☐	☐	☐
	Thyroid disease	☐	☐	☐

Additional Information (List any extra medication, procedure or condition not already covered or listed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____ **Date**_____