SLEZAK COLORECTAL SURGICAL CLINIC, PL
PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____

Who recommended you to this office? _____

HISTORY OF PRESENT ILLNESS:

What are you being seen for today: _____

_____

When did this begin: _____ Have you ever had this problem before: { }Yes { }No

Has any other physician seen you for this condition: { }Yes { }No Name: _____

Family Physician: _____

MEDICAL HISTORY: Please check all that apply _____

{ } Alcoholism
{ } Asthma
{ } Blood Clots
{ } Blood Diseases
{ } Anemia
{ } Leukemia
{ } Blood Pressure - High
{ } Bronchitis
{ } Cataracts
{ } Cholesterol - High
{ } Crohns Disease
{ } Colitis Ulcerative
{ } Diabetes
{ } Diverticulitis
{ } Drug Addition
{ } Emphysema
{ } Epilepsy
{ } Glaucoma
{ } Gout
{ } Heart Disease
{ } Abnormal Rhythm
{ } Congestive Heart Failure
{ } Mitral Valve Prolapse
{ } Murmurs
{ } Hepatitis
{ } Hernia
{ } HIV Positive
{ } Irritable Bowel Syndrome
{ } Kidney Disease
{ } Kidney Cysts
{ } Kidney Stones
{ } Latex Allergy
{ } Liver Cirrhosis
{ } Osteoporosis
{ } Parkinsonism
{ } Peptic Ulcers
{ } Prostate -
{ } Enlarged
{ } Inflammation
{ } Cancer
{ } Psoriasis
{ } Stroke
{ } Thyroid Disease
{ } Tuberculosis
{ } Arthritis _____
{ } Blood Transfusion (when) _____
{ } Cancer (Type)_____
{ } Fracture/Broken Bones (where)
_____
{ } Other _____
_____

Drug Allergies: { } None OR List _____

MEDICATIONS – Please list all medications you are presently taking.
Example : Medication Synthroid Mg. .5 Dosage: 1 per day

Medication	Mg.	Dosage	Medication	Mg.	Dosage

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PAST PROCEDURE: Please check all that apply & enter year, complications & left or right _____

PROCEDURE (Year, Left or Right, Complications)	PROCEDURE (Year, Left or Right, Complications)
{ } Colonoscopy_____	{ } Skin Cancer_____
{ } Colon Surgery_____	{ } Arthroscopy_____
{ } Flexible Sigmoidoscopy_____	{ } Joint Replacement(location)_____
{ } Barium Enema_____	{ } Cataract Procedure_____
{ } Virtual Colonoscopy_____	{ } Pacemaker_____
{ } Cesarean Section_____	{ } Prostate PROCEDURE _____
{ } D & C_____	{ } Back PROCEDURE_____
{ } Hysterectomy_____	{ } Neck PROCEDURE_____
{ } Appendectomy_____	{ } Kidney PROCEDURE_____
{ } Heart Valve Replacement_____	{ } Breast Procedure_____
{ } Heart Stents_____	{ } Tonsillectomy_____
{ } Heart Bypass_____	{ } Other_____
{ } Gallbladder PROCEDURE_____	

SOCIAL HISTORY – Please check all that apply.

☐ Yes ☐ No Have you ever smoked tobacco> How much per day? _____ When did you quit? _____

☐ Yes ☐ No Have you ever taken banned substances? What: _____

☐ Yes ☐ No Are you currently taking any over the counter drugs? What: _____

☐ Yes ☐ No Are you currently taking any herbal drugs? What: _____

☐ Yes ☐ No Do you consume alcohol? How much: _____

☐ Yes ☐ No Are you currently taking any prescribed or over the counter diet pills? What: _____

☐ Yes ☐ No Are you currently taking any blood thinners (i.e. aspirin, ibuprofen, coumadin, plavix, vitamin E supplement)?

What: _____

FAMILY HISTORY: _____

Please list any blood relative and their relationship to you that have had any of the following (paternal or maternal):

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Rheumatoid Arthritis _____

Colon Cancer _____ Other Cancer _____

Inflammatory Bowel Disease _____

Other _____

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SYSTEM REVIEW: Please circle all that apply today _____

GENERAL:	Chills	Sweats	Anorexia	Fatigue
	Weight loss	Weight gain		
EYES:	Visual changes	Blurring	Double vision	Irritation
	Discharge	Loss	Pain	Pain in sun
EAR NOSE THROAT:	Earache	Ringing in ears	Hearing loss	Sore throat
	Post nasal drip	Runny nose	Facial pressure	Painful teeth
RESP:	Cough	Shortness of breath	Difficult breathing	Coughing blood
	COPD	Emphysema		
CARDIO/VASCULAR:	Chest pain	Palpitations	Syncope	
	Difficulty on Exercising	PND	Edema	Tachycardia
GASTRO INTESTINAL:	Vomiting	Heart Burn	Reflux	Anorexia
	Diarrhea	Constipation	Black stools	Bloody stools
	Abdominal pain			
GENITAL/URINARY:	Painful Urination	Frequency	Hesitancy	Urgency
	Nighttime	Urination	Bloody Urine	Sores
	Discharge	Testicle pain		
GYNOCOLOGY:	Discharge	Odor	Pelvic pain	Painful coitus
	Sores	Irregular menses		
MUSCULOSKELETAL:	Back pain	Joint Pain	Joint swelling	Muscle Pain
	Decreased ROM	Altered gait		
SKIN:	Rash	Itching	Dryness	Ulcers
	Bruising	Bleeding under skin	Redness of skin	
	Pinpoint red/purple spots	Hardened skin due to swelling		
ENDOCRINE:	Heat/cold intolerance	Increase thirst	Increase hunger	Increase urination
NEUROLOGY:	Weakness	Abnormal sensation	Painful skin	Seizures Tremor
	Dizziness	Headache		
PSYCHOLOGY:	Depression	Anxiety	Panic	Memory loss
	Suicidal thoughts	Agitation	Unstable mood	Insomnia
	Loss of contact with reality			
HEME/LYMPH/ID:	Abnormal bleeding	Bruising	Swollen glands	Anemia
	Transfusion	HIV exposure		

Sexually transmitted diseases: _____

OTHER: _____