HEALTH HISTORY FORM (1)

Welcome to North Texas Colon and Rectal Associates.

Thank you for choosing our clinic for your health care needs! We appreciate your assistance with completing this form as it will help us better care for you.
This is confidential information and will be kept in your electronic health record.

Name:

DOB:

Date:

Reason for Visit:

Primary care physician/Referring physician:

Pharmacy (Address or cross street/Phone):

Medications:	**Dose and Frequency:**

Allergies (food and drugs): Please list the type of reaction next to each allergy

Past Medical History: Check all that apply

___ Cancer/Type:	___ COPD/Emphysema
___ Ulcerative Colitis	___ Diabetes
___ Crohn's disease	___ GERD
___ Anxiety/Depression	___ Hepatitis or other liver disease
___ Arthritis	___ High Blood Pressure
___ Asthma	___ High Cholesterol
___ Cataracts	___ HIV/AIDS
___ Congestive Heart Failure	___ Kidney disease
___ Cardiovascular disease/ Heart Attack	___ Thyroid disease
___ Clotting/Bleeding Disorder	___ Other:

Past Surgical History: Check all that apply. Please include dates of surgery

___ Abdomen Surgery:	___ Other:
___ Appendectomy	
___ Breast Surgery	
___ Cholecystectomy (Gallbladder surgery)	
___ C-Section	
___ Hernia repair	
___ Hysterectomy	
___ Bone surgery	

Have you had a colonoscopy?
Date:
Findings:

Social History:

Do you drink alcohol?	___ NO ___YES, number of drinks per week:
Do you smoke or use tobacco products?	___ NEVER BEFORE ___ NO, I quit. when?___ ___ YES, packs per day ___, for ___years
Do you use other drugs?	___ NO ___YES, please list:

HEALTH HISTORY FORM (2)

Family History: Please write **age of diagnosis** in the appropriate box

Relationship	**Deceased (Y/N)**	**Heart Disease**	**Colon Polyps**	**Colorectal Cancer**	**Endometrial (Uterus) Cancer**	**Ovarian Cancer**	**Breast Cancer**	**Kidney Cancer**	**Thyroid Cancer**	**Pancreas Cancer**	**Stomach Cancer**	**IBD (UC, Crohns)**	**Other**
Mother													
Father													
Sister(s)													
Brother(s)													
Daughter(s)													
Son(s)													
Maternal Aunts(s) Uncle(s)													
Paternal Aunt(s) Uncle(s)													
Maternal Grandmother													
Maternal Grandfather													
Paternal Grandmother													
Paternal Grandfather													
Other:													

Review of Systems: Mark if you have had any of these symptoms in the **past year**. Check all that apply

By leaving symptoms unchecked, I state that **I do not have any of the unchecked symptoms**

___ Weight loss	___Chest pain	___ Incontinence of stool
___ Fatigue	___ Shortness of breath	___ Blood in stool or black tarry stool
___ Dizziness	___ Cough	___ Constipation/Diarrhea
___ Change in hearing	___ Pain with urination	___ Changes in temperature/ “hot flashes”
___ Change in vision	___ Incontinence of urine	___ Skin dryness/ skin thickening
___ Changes in memory/cognition	___ Prostate problems/nighttime urination	___ Excessive thirst
___ Difficulty with balance/falls	___ Stomach pain	___ Muscle pain/weakness
___ Nasal or Sinus symptoms	___ Difficulty swallowing	___ Joint pain- Location: _____
___ Neck mass or swelling	___ Reflux, belching	___ Numbness/tingling- Location:_____
___ Seasonal allergies	___ Nausea/Vomiting	___ Anxiety/Depression

Health Screening:

Have you had an annual wellness exam? ___N ___Y, date: _____

For women: Have you had a mammogram? ___ N ___ Y, date:_____
Have you had a PAP screen? ___ N ___ Y, date:_____

For men: Have you had a testicular exam? ___ N ___ Y, date: _____