MR#
Name of Patient
Date of Birth
Place Label Here

Surgery Faculty Practice
COLON & RECTAL SURGERY
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http://www.ucdmc.ucdavis.edu/surgery/specialties/colorectal

UCDAVIS HEALTH

NEW PATIENT HISTORY FORM

Name:	**Date of Birth:**
Referring Physician:	**Primary Care Physician:**
Any other physician who should receive an update of your records?	

Why are you here today?

COLON & ANORECTAL HISTORY

	RECTAL BLEEDING	ANAL PAIN	RECTAL DRAINAGE	ANAL MASS	ABDOMINAL PAIN
1. Do you have any of the following?	☐	☐	☐	☐	☐
2.For how long? *(days, weeks, months, yrs.)*					
3. What makes it better?					
4. What makes it worse?					
5.Any other relevant details?	☐ Bright Red ☐ Maroon ☐ On Stool ☐ Mixed in Stool ☐ In toilet water ☐ On toilet paper	☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning	☐ Pus ☐ Stool ☐ Yellow Fluid ☐ Mucous	☐ Firm ☐ Soft ☐ Growing ☐ Shrinking	☐ Upper ☐ Lower ☐ Right ☐ Left ☐ Middle ☐ Dull ☐ Sharp

	YES	NO
6. Have you lost any weight?	☐	☐
If yes, how many pounds _____ *Over How much time* _____		
Why did you lose weight: ☐ Pain ☐ Dieting ☐ Exercising ☐ Loss of Appetite		
Other: _____		
7. Number of BMs: _____ ☐ per day OR ☐ per week		
Are they: ☐ Hard ☐ Soft ☐ Mushy ☐ Liquid		
Any problems with control of solid stool?	☐	☐
Any problems with control of liquid stool?	☐	☐
Any problems with control of gas?	☐	☐
8. Do you take: ☐ Fiber ☐ Laxatives ☐ Anti-Diarrhea		
What kind of fiber, laxative, and or anti-diarrhea medications do you take? _____		
How often do you take it? _____		
9. Do you use medications on your anus?	☐	☐
If yes, what kind _____ *How often?* _____		

	YES	NO
10. Have you ever had anal surgery?	☐	☐
What procedure(s)? _____		
Where? _____ *When?* _____		
11. Do you have a stoma? (If yes answer a.)	☐	☐
a. Do you want to see a stoma therapist?	☐	☐
12. Do you need to see a wound nurse?	☐	☐
13. Have you ever had a colonoscopy?	☐	☐
What Year(s)? _____ *Where?* _____		
Did it show anything abnormal?	☐	☐
14. Has your symptoms changed since your last scope?	☐	☐
15. Have you ever had a barium enema study?	☐	☐
What Year(s)? _____ *Where?* _____		
Did it show anything abnormal?	☐	☐
16. Have you ever had colon polyps?	☐	☐
17. Did you ever have 10 or more polyps?	☐	☐

Name: _____

PAST MEDICAL HISTORY

18. Please list all medical problems/issues:

PAST SURGICAL HISTORY

19. Please list all your previous operations:	**Date**	**Hospital**

MEDICATIONS

	YES	NO
20. Are you allergic to any medicines/foods/agents?	☐	☐

If so, please list:

21. Please list all medications, supplements, you take regularly *(If you were seen at UC Davis prior, please skip this section)***:**

Name	***Dose***	***Times per day***

FAMILY HISTORY

	YES	NO
22. Any relatives with Crohn's or Ulcerative Colitis?	☐	☐

Please list who and which disease:

23. Any relatives with a history of cancer?	☐	☐

Relative	**How many had cancer?**	**What type of cancer?**	**How many had Cancer < 50yrs. old**	**How many are alive?**
Mother				
Maternal Grandmother				
Maternal Grandfather				
Maternal Aunt(s)				
Maternal Uncle(s)				
Maternal Cousins				
Father				
Paternal Grandmother				
Paternal Grandfather				
Paternal Aunt(s)				
Paternal Uncle(s)				
Paternal Cousin(s)				
Siblings				
Niece(s)				
Nephew(s)				
Children				
Grandchildren				

Name: _____

SOCIAL HISTORY	YES	NO
24. Are you: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed		
25. Do You Live Alone?	☐	☐
26. Difficulty w/ transportation home after surgery?	☐	☐
27. Difficulty arranging help at home after surgery?	☐	☐
28. If you are disabled, why? _____ *If not, what do you do for a living?* _____		
29. Do you currently or have you ever smoked? *When did you start smoking?* _____ *How many packs per day?* _____	☐	☐
30. Have you quit smoking? **OR** Would you like aids/help to quit smoking?	☐ ☐	☐ ☐
31. Do you use any of the following? ☐ Hooka ☐ Pipe ☐ Vapor Cigarettes ☐ Marijuana ☐ Smokeless Tobacco/Chew ☐ E-Cigarettes *Started?* _____ *Quit?* _____ *How often?* _____		
32. How many alcoholic drinks do you have per week? _____		
33. Do you drink alcohol daily?	☐	☐
34. Do you get shaky if you do not drink for 3 days?	☐	☐
35. Do you use any recreational drugs? *If yes, list what they are:* _____	☐	☐
36. Have you used drugs in the last 3 months?	☐	☐

GYNECOLOGICAL HISTORY (Women)	YES	NO
37. Have you ever had an abnormal pap smear? *If yes, when?* _____	☐	☐
38. How many times have you been pregnant? _____		
39 How many times have you given birth? _____		
40. Forceps or Vacuum deliveries?	☐	☐
41. Vaginal Injury/tear, or episiotomy?	☐	☐

WITHIN THE PAST 6 MONTHS	YES	NO
42. **In the last 6 months have you had:**		
Difficulty climbing 2 flights of stairs due to shortness of breath?	☐	☐
Daily cough with mucous production?	☐	☐
Chest Pain?	☐	☐
Nausea?	☐	☐
Vomiting?	☐	☐
Decreased appetite?	☐	☐
Fatigue / Weakness	☐	☐
Excessive thirst?	☐	☐
Urinary Frequency?	☐	☐
Urinary Urgency?	☐	☐
Trouble starting or stopping urine stream?	☐	☐
Urinary incontinence?	☐	☐
Getting up at night to urinate?	☐	☐
Painful urination?	☐	☐
Pass air with urine?	☐	☐
Pain with sex?	☐	☐
MEN: *Problems achieving an erection?*	☐	☐
MEN: *Problems achieving ejaculation?*	☐	☐
Problems achieving orgasm?	☐	☐
WOMEN: *Stool from vagina?*	☐	☐
WOMEN: *Gas from vagina?*	☐	☐
Have you fallen?	☐	☐
Arthritis, Joint Pain?	☐	☐
Anxiety / Excessive worry?	☐	☐
Anemia?	☐	☐
Fevers?	☐	☐

Name: _____

WITHIN THE PAST 6 MONTHS	YES	NO
43. **In the last 6 months have you had:**		
Chills?	☐	☐
Night Sweats?	☐	☐
Difficulty Hearing?	☐	☐
Limited Movement of Neck or Jaw?	☐	☐
Problems with Teeth?	☐	☐
Oral ulcers / Canker Sores?	☐	☐
Difficulty Walking 2 Blocks due to Shortness of Breath?	☐	☐
Rashes?	☐	☐
Antibiotics?	☐	☐
If so, what kind? _____		

	YES	NO
44a. **Have you ever had:**		
Bronchitis?	☐	☐
Tuberculosis?	☐	☐
Emphysema?	☐	☐
Angina?	☐	☐
Heart Attack?	☐	☐
If yes, when? _____		
Leg Swelling?	☐	☐
Congestive Heart Failure?	☐	☐
Sleep on 2+ pillows or wake up due to shortness of breath?	☐	☐
High Blood Pressure / Hypertension?	☐	☐
Difficulty walking 2 blocks due to leg pain?	☐	☐
Difficulty walking 2 flights of stairs due to leg pain?	☐	☐
Heart murmur?	☐	☐
Irregular Heart Rhythm?	☐	☐

HAVE YOU EVER HAD (Continued)	YES	NO
44b. **Have you ever had:**		
Atrial Fibrillation?	☐	☐
Mitral Valve Prolapse?	☐	☐
Liver Disease / Cirrhosis?	☐	☐
Hepatitis / Jaundice?	☐	☐
Diabetes?	☐	☐
Problems with: High Blood Sugar	☐	☐
Low Blood Sugar	☐	☐
Sexually Transmitted Disease(s)	☐	☐
If so which and when? _____		
Steroid use, oral or intravenous?	☐	☐
If so when and why? _____		
Seizure, Epilepsy?	☐	☐
If yes how often? _____		
If yes, Last Seizure? _____		
Stroke, TIA, fleeting blindness?	☐	☐
When? _____		
Ankylosing Spondylitis?	☐	☐
Psychiatric treatment with medication?	☐	☐
Claustrophobia?	☐	☐
Depression?	☐	☐
Bleeding Problems?	☐	☐
Blood Clots?	☐	☐
Where? (i.e. Arm, Lung) _____ *When?* _____		
Need antibiotics before dental procedures?	☐	☐
Have you ever had a family member get a high fever due to anesthesia (Malignant Hypertension)?	☐	☐
If yes, who: _____ *When?* _____		
Have you had any problems with previous surgeries due to intubations?	☐	☐
Any other problems with Anesthesia _____		

45. Anything else we should know about your health: