HealthPoint
Medical Group

New Patient Health Questionnaire
Colon & Rectal Surgery Supplement

Name: _____ Date: _____

DOB: _____ Age: _____ New Patient _____ Established _____

Primary Complaint: _____ How Long?: _____

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

Medical History: Please indicate if you have had any of the following symptoms:

Yes	No	How long?		
			Rectal pain	**Anal Symptoms**
			Rectal bleeding	
			Itching/burning	
			Protrusion/swelling	
			Discharge	

Yes	No	How long?		
			Abdominal pain	**Gastrointestinal Symptoms**
			Nausea	
			Constipation	
			Diarrhea	
			Blood in stool	
			Change in bowel habits	
			Fecal incontinence	
			Diverticulosis	
			Vomiting	
			Abdominal pain	

Medical History: Please indicate if you have had any of the following diseases:

Yes	No	When?		
			Chlamydia	**Past Medical History**
			Herpes	
			Hepatitis	
			Gonorrhea	
			Venereal warts	

Family Medical History: Please indicate if you or a family member has had any of the following diseases:

Self	Family	None		
			Colon cancer	**Family Medical History**
			Colon polyps	
			Ulcerative colitis	
			Crohn's disease	
			Other cancers	
			Heart disease	
			High blood pressure	
			Diabetes	
			Stroke	
			Phlebitis	
			Thyroid disease	
			Sickle cell disease	
			Blood clotting	

Have you had a colonoscopy or flexible sigmoidoscopy? No ____ Yes ____ Why? _____
How often do you move your bowels? _____
Do you need to take antibiotics before any surgical or dental procedure? No ____ Yes ____ Why? _____

Physician Signature: _____ Date: _____