HealthPoint
Medical Group

New Patient Health Questionnaire

Colon & Rectal Surgery Supplement

Name: _____ Date: _____

DOB: _____ Account #: _____

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.**

Family History of Medical Problems

MP	Male Parent (Father)	PGF	Paternal Grandfather	MGF	Maternal Grandfather
FP	Female Parent (Mother)	PGM	Paternal Grandmother	MGM	Maternal Grandmother
CM	Male Child (Son)	PU	Paternal Uncle	MU	Maternal Uncle
CF	Female Child (Daughter)	PA	Paternal Aunt	MA	Maternal Aunt
SM	Male Sibling (Brother)	PC	Paternal Cousin	MC	Maternal Cousin
SF	Female Sibling (Sister)				

Please indicate in the appropriate box if any of your family members have had the following medical problems. Use the abbreviations in the table above to indicate the relationship :

Condition	**Family Member**
Diabetes	
Hypertension	
Heart Disease	
Vascular Disease	
Stroke	
High Cholesterol	
Other Non-cancer Disease:	
Breast Cancer	
Colon/Rectal Cancer	
Ovarian Cancer	
Prostate Cancer	
Uterine Cancer	
Uterine Polyps	
Other Cancers:	

Physician Signature: _____ Date: _____