UM/ST. JOSEPH COLON RECTAL SURGEONS
PATIENT INFORMATION UPDATE FORM

Name: _____ Age: _____ Date: _____

Referring Doctor: _____

Primary Care Physician (if different from above): _____

Chief Reason for visit: _____

How long have you had this problem: _____ Days _____ Months _____ Years

Rectal Bleeding

Bright red _____
Dark _____
Mixed into stool _____
Sitting on stool _____
Clots _____

Anal Pain

Itching _____
Burning _____

Mucus Discharge _____

Abdominal Pain

Upper Abd _____
Lower Abd _____
Right side _____
Left side _____

Bloating _____

Bowel Habits

Constipation _____ How long? _____
Diarrhea _____ How long? _____
Change in frequency _____ Explain: _____
Strain at BM _____ Explain: _____
Incontinence: Gas _____ Liquid _____ Solid _____ Urgency _____

Family History: Colon/Rectal Cancer _____ Colon polyps _____
Ulcerative Colitis _____ Crohn's disease _____
Social History: Cigarette Smoking _____ pack/day; Alcohol use _____ day or week
Drug usage _____

Please circle all that apply:

Constitutional: Fever; weight loss; other _____
Allergies: Hay Fever; sinusitis; latex allergy
Skin: Rash; lesions; breast lumps
EENT: Loss of hearing; visual loss; sleep apnea; mouth ulcers; nose bleeds
Heme/Lymph: Anemia; bleeding disorders
Heart Problems: Chest pain; irregular heart beat; murmur; other _____
Lung Problems: Asthma; Emphysema; Shortness of breath; other _____
Kidney/Bladder Problems: Incontinence; hesitancy; frequency; impotency
Neurologic: Weakness; seizures; depression

New medical problems: High blood pressure; diabetes; thyroid problems; arthritis;
Hepatitis (type/when) _____, HIV, Elevated Cholesterol;
Other _____

Medications: (name, dosage and frequency) _____
_____
_____
_____
_____
_____

Allergies/Medication Allergies: _____
_____
_____
_____

Additional Surgeries since last visit: _____
_____
_____

Reviewed by (Physician initials/date) _____