SLEZAK COLORECTAL SURGICAL CLINIC, PL
PATIENT MEDICAL HISTORY

Patient Name: ______________________________ Date of Birth: ____________ Age: ________________

Who recommended you to this office? ____

HISTORY OF PRESENT ILLNESS:

What are you being seen for today: ____

____

When did this begin: ____________________ Have you ever had this problem before: { }Yes { }No

Has any other physician seen you for this condition: { }Yes { }No Name: ______________________

Family Physician: ____

MEDICAL HISTORY: Please check all that apply ______________________________________

{ } Alcoholism
{ } Asthma
{ } Blood Clots
{ } Blood Diseases
  { } Anemia
  { } Leukemia
{ } Blood Pressure - High
{ } Bronchitis
{ } Cataracts
{ } Cholesterol - High
{ } Crohns Disease
{ } Colitis Ulcerative
{ } Diabetes
{ } Diverticulitis
{ } Drug Addition
{ } Emphysema
{ } Epilepsy

{ } Glaucoma
{ } Gout
{ } Heart Disease
  { } Abnormal Rhythm
  { } Congestive Heart Failure
  { } Mitral Valve Prolapse
  { } Murmurs
{ } Hepatitis
{ } Hernia
{ } HIV Positive
{ } Irritable Bowel Syndrome
{ } Kidney Disease
{ } Kidney Cysts
{ } Kidney Stones
{ } Latex Allergy
{ } Liver Cirrhosis
{ } Osteoporosis

{ } Parkinsonism
{ } Peptic Ulcers
{ } Prostate -
  { } Enlarged
  { } Inflammation
  { } Cancer
{ } Psoriasis
{ } Stroke
{ } Thyroid Disease
{ } Tuberculosis
{ } Arthritis ____________________
{ } Blood Transfusion (when) _______
{ } Cancer (Type)________________
{ } Fracture/Broken Bones (where)
____
{ } Other ______________________
____

Drug Allergies: { } None OR List ____

MEDICATIONS – Please list all medications you are presently taking.
Example : Medication Synthroid Mg. .5 Dosage: 1 per day

Medication	Mg.	Dosage	Medication	Mg.	Dosage

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PAST PROCEDURE: Please check all that apply & enter year, complications & left or right ____________

PROCEDURE (Year, Left or Right, Complications)

{ } Colonoscopy____________________
{ } Colon Surgery____________________
{ } Flexible Sigmoidoscopy____________________
{ } Barium Enema____________________
{ } Virtual Colonoscopy____________________
{ } Cesarean Section____________________
{ } D & C____________________
{ } Hysterectomy____________________
{ } Appendectomy____________________
{ } Heart Valve Replacement____________________
{ } Heart Stents____________________
{ } Heart Bypass____________________
{ } Gallbladder PROCEDURE____________________

PROCEDURE (Year, Left or Right, Complications)

{ } Skin Cancer____________________
{ } Arthroscopy____________________
{ } Joint Replacement(location)____________________
{ } Cataract Procedure____________________
{ } Pacemaker____________________
{ } Prostate PROCEDURE ____________________
{ } Back PROCEDURE____________________
{ } Neck PROCEDURE____________________
{ } Kidney PROCEDURE____________________
{ } Breast Procedure____________________
{ } Tonsillectomy____________________
{ } Other____________________

SOCIAL HISTORY – Please check all that apply.

☐ Yes ☐ No Have you ever smoked tobacco> How much per day? __________ When did you quit? __________

☐ Yes ☐ No Have you ever taken banned substances? What: ____________________

☐ Yes ☐ No Are you currently taking any over the counter drugs? What: ____________________

☐ Yes ☐ No Are you currently taking any herbal drugs? What: ____________________

☐ Yes ☐ No Do you consume alcohol? How much: ____________________

☐ Yes ☐ No Are you currently taking any prescribed or over the counter diet pills? What: ____________________

☐ Yes ☐ No Are you currently taking any blood thinners (i.e. aspirin, ibuprofen, coumadin, plavix, vitamin E supplement)?

What: ____________________

FAMILY HISTORY: ____________________

Please list any blood relative and their relationship to you that have had any of the following (paternal or maternal):

Diabetes ____________________ High Blood Pressure ____________________

Heart Disease ____________________ Rheumatoid Arthritis ____________________

Colon Cancer ____________________ Other Cancer ____________________

Inflammatory Bowel Disease ____________________

Other ____________________

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SYSTEM REVIEW: Please circle all that apply today ______________________________

GENERAL:	Chills Weight loss	Sweats Weight gain	Anorexia	Fatigue
EYES:	Visual changes Discharge	Blurring Loss	Double vision Pain	Irritation Pain in sun
EAR NOSE THROAT:	Earache Post nasal drip	Ringing in ears Runny nose	Hearing loss Facial pressure	Sore throat Painful teeth
RESP:	Cough COPD	Shortness of breath Emphysema	Difficult breathing	Coughing blood
CARDIO/VASCULAR:	Chest pain Difficulty on Exercising	Palpitations PND	Syncope Edema	 Tachycardia
GASTRO INTESTINAL:	Vomiting Diarrhea Abdominal pain	Heart Burn Constipation	Reflux Black stools	Anorexia Bloody stools
GENITAL/URINARY:	Painful Urination Nighttime Discharge	Frequency Urination Testicle pain	Hesitancy Bloody Urine	Urgency Sores
GYNOCOLOGY:	Discharge Sores	Odor Irregular menses	Pelvic pain	Painful coitus
MUSCULOSKELETAL:	Back pain Decreased ROM	Joint Pain Altered gait	Joint swelling	Muscle Pain
SKIN:	Rash Bruising Pinpoint red/purple spots	Itching Bleeding under skin Hardened skin due to swelling	Dryness Redness of skin	Ulcers
ENDOCRINE:	Heat/cold intolerance	Increase thirst	Increase hunger	Increase urination
NEUROLOGY:	Weakness Dizziness	Abnormal sensation Headache	Painful skin	Seizures Tremor
PSYCHOLOGY:	Depression Suicidal thoughts Loss of contact with reality	Anxiety Agitation	Panic Unstable mood	Memory loss Insomnia
HEME/LYMPH/ID:	Abnormal bleeding Transfusion	Bruising HIV exposure	Swollen glands	Anemia

Sexually transmitted diseases: ______________________________

OTHER: ______________________________