UCLA Colon and Rectal Surgery

Initial Visit Health History Form

All information contained in this questionnaire is strictly confidential
and will become part of your medical record.

Name:	**DOB:**	**AGE:**
Home address: *(Street):* *(City/State/Zip)*	**Home phone:** **Cell phone:**	
NEAREST RELATIVE/EMERGENCY CONTACT		
Name:	**Home phone:**	
Relation to you:	**Cell phone:**	
YOUR DOCTOR'S CONTACT INFORMATION		
Referring MD:	**Primary MD:**	
Street Address: City/State/Zip:	Street Address: City/State/Zip:	
Phone:	Phone:	
Fax:	Fax:	

MEDICAL HISTORY

Have you ever had a colonoscopy?

How many bowel movements do you have per day?

Do you have problems with fecal incontinence or soiling?

FOR WOMEN: Last PAP smear? **Last mammogram?**

Please list your Medical Conditions.

(Attach additional sheet if necessary)

SURGICAL HISTORY

PLEASE LIST ALL SURGERIES YOU HAVE HAD

OPERATION / YEAR	OPERATION / YEAR	OPERATION / YEAR

MEDICATIONS

(ATTACH ADDITIONAL SHEET IF NECESSARY)

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

NAME:

DO YOU HAVE ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO

If yes, please list the medication and your reaction

MEDICATION	REACTION

SOCIAL HISTORY

OCCUPATION:		**MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ PARTNERED ☐ WIDOWED			
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – pks/day	☐ Cigars - #/day			
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

DO ANY OF THESE CONDITIONS RUN IN YOUR FAMILY?

COLON CANCER? ☐ YES ☐ NO	**CROHN'S DISEASE?** ☐ YES ☐ NO
ULCERATIVE COLITIS? ☐ YES ☐ NO	**COLON POLYPS?** ☐ YES ☐ NO

PLEASE LIST ANY OTHER MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY

NAME:

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?					
Constitutional: Fever or chills	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No
Skin: Rash	☐ Yes ☐ No	Itching	☐ Yes ☐ No	Bruising	☐ Yes ☐ No
Eyes: Blurry vision	☐ Yes ☐ No	Excessive Tearing	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Ears, Nose, Mouth: Ringing in ears	☐ Yes ☐ No	Nosebleeds	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No
Cardiovascular: Chest Pain	☐ Yes ☐ No	Palpitations	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Respiratory: Cough	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Gastrointestinal: Abdominal Pain	☐ Yes ☐ No	Nuasea/Vomiting	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Genitourinary: Frequent Urination	☐ Yes ☐ No	Painful Urination	☐ Yes ☐ No	Blood in the Urine	☐ Yes ☐ No
Musculoskeletal: Muscle Pain	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Neurologic: Fainting/Dizzyness	☐ Yes ☐ No	Strokes	☐ Yes ☐ No	Memory Loss	☐ Yes ☐ No
Other:	☐ Yes ☐ No	**Other:**	☐ Yes ☐ No	**Other:**	☐ Yes ☐ No

NAME: