Joshua M. Braveman M.D., FACS, FASCRS - Colon & Rectal Surgery Intake Form

Name:			Social Security Number:
Street Address:	City:	State:	Zip:
Age:	Birthdate:	Primary Care Doctor:	
What is your reason for visit?		Referring Doctor (if different than above)	

Location:

Timing (with BMs):

Quality (Sharp/dull):

Modifying Factors:

Severity:

Associated Symptoms:

Duration:

PAST MEDICAL HISTORY (Check all that apply)

☐ Hypertension	☐ Diabetes	☐ Bleeding Tendency
☐ Heart Disease	☐ Kidney disease	☐ Lung Disease
☐ Liver Disease	☐ Cancer	☐ Diverticulitis
☐ Inflammatory bowel disease	☐ HIV/AIDS/STD	☐ Childbirth Injury
☐ Anorectal problems	☐ Irritable Bowel Syndrome	☐ Thyroid

Any other problems not on the list? Please list:

PAST SURGICAL HISTORY (please list all past operations of any type)

Have you had a colonoscopy or barium enema?	When? Where? Why?	
MEDICATIONS List medications and dosages you are currently taking or attach a list		**ALLERGIES: (please list and indicate reaction to drug)**
		☐ **NONE**

Are you taking any blood thinners (Coumadin, Plavix) or aspirin products (Aspirin, Motrin, Advil, Aleve)? _____ Yes _____ No

REVIEW OF SYSTEMS (Please check all that apply):

Height: _____ ft _____ in Weight: _____ lbs

GEN
- ☐ Weight loss or gain
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Fatique
- ☐ Loss of appetite

SKIN
- ☐ Rash
- ☐ Unhealed cuts or wounds
- ☐ Itching
- ☐ Pilonidal
- ☐ Hidradenitis

HEAD, EYES, EARS, NOSE, THROAT
- ☐ Headache
- ☐ Double Vision/Blurred Vision
- ☐ Glasses/contacts
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Dentures Upper
- ☐ Dentures Lower

LUNGS
- ☐ Cough
- ☐ Shortness of breath @ rest
- ☐ Shortness of breath with exertion
- ☐ Wheezing
- ☐ TB

HEART
- ☐ Angina/chest pain
- ☐ Palpitations
- ☐ Irreg heart beat/arrhythmia
- ☐ Murmur
- ☐ I take antibiotics before going to the dentist
- ☐ My Cardiologist is:

_____

VASCULAR
- ☐ History of blood clots, DVT, or PE
- ☐ Leg swelling
- ☐ Varicose veins
- ☐ Stroke

GI
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ GERD/heartburn
- ☐ Liver problems/gallstones
- ☐ Black stools
- ☐ Blood with bowel movements
- ☐ Pain with BM
- ☐ My bowel habits have changed
- ☐ Bowel accidents
- ☐ Anal fissure
- ☐ Anal abscess/fistula
- ☐ My Gastroenterologist is:

_____

KIDNEYS/URINE
- ☐ Hematuria
- ☐ Burning
- ☐ Frequency
- ☐ Hesitancy urinary incontinence
- ☐ History of UTIs
- ☐ Prostate problems
- ☐ My Urologist is:

_____

NEUROLOGICAL
- ☐ Fainting
- ☐ History of falls
- ☐ Seizures
- ☐ Loss of memory
- ☐ Stroke

MUSCULOSKEL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Arthritis

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety/panic disorder

SOCIAL HISTORY
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Occupation:

ALCOHOL USE
- ☐ NONE
- ☐ Social
- ☐ Habitual _____

SMOKING
- ☐ NO
- ☐ YES ____ Packs per day/ ____ years
- ☐ Quit, when? _____

FAMILY HISTORY
- ☐ Cancer Who/age of diagnosis?
- ☐ Colon polyps Who/age of diagnosis?
- ☐ Inflammatory bowel disease Who/age of diagnosis?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

_____ _____
Patient Signature Date

_____ _____
Reviewed By Signature Date