

## 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:			
<b>PAST MEDICAL HISTORY (Check all that apply)</b>			
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Tendency	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diverticulitis	
<input type="checkbox"/> Inflammatory bowel disease	<input type="checkbox"/> HIV/AIDS/STD	<input type="checkbox"/> Childbirth Injury	
<input type="checkbox"/> Anorectal problems	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Thyroid	
Any other problems not on the list? Please list:			
<b>PAST SURGICAL HISTORY (please list all past operations of any type)</b>			
<i>Have you had a colonoscopy or barium enema?</i>		When?	
		Where?	
		Why?	
<b>MEDICATIONS</b> List medications and dosages you are currently taking or attach a list		<b>ALLERGIES: (please list and indicate reaction to drug)</b>	
		<input type="checkbox"/> 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
- Fatigue
- 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

- Nausea/vomiting
- Diarrhea
- Constipation
- Abdominal pain
- GERD/heartburn
- Liver problems/gallstones
- Black stools

**GI**

- 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

**ALCOHOL USE**

- NONE
- Social \_\_\_\_\_
- Habitual \_\_\_\_\_

**SMOKING**

- NO
- YES \_\_\_\_\_ Packs per day/ \_\_\_\_\_ years
- Quit, when? \_\_\_\_\_

Occupation: \_\_\_\_\_

**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