ACRS

ATLANTA COLON & RECTAL SURGERY, P.A.

Today's date:_____

Patient Name:_____ **Birth Date:**_____

Race:_____ **Marital Status:** Single Married Widowed Divorced

Employer: _____ **Spouse's Name:** _____

Current Medications & Dosage

(If you do not know the drug name, list the condition)

_____ _____ _____ _____

_____ _____ _____ _____

Please list all your **DRUG ALLERGIES:** _____

Social History

Do you smoke?_____ Frequency_____
Do you consume alcohol?_____ Frequency_____
Do you take drugs?_____ Frequency_____

Past Medical History

Have you ever experienced any of the following conditions? (Please check all that apply.)

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder Infection
- ☐ DVT
- ☐ Pulmonary Embolism
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV +
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pneumonia
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Urinary / Prostate
- ☐ Other History:

Past Surgical History

_____

_____

_____

Have you ever had a colonoscopy? Yes No

If yes, when_____ and results _____

Family Medical History

	Relative	Condition & Age	None
Family History of Cancer			
Family History of Colon Polyps/Tumors			
Family History of Colon Disease			

Patient Name: _____ **Date of Birth:** _____

Present Medical Complaints

Reason for your visit:

_____

Please indicate either a yes or no response next to each item. Please do not leave blanks. *For physician review purposes, any type of mark (e.g. line, X, check, etc.) will indicate a negative or positive response and not a deferment.*

Review of Systems	No	Yes
Constitutional		
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue/Weakness	☐	☐
Gastrointestinal		
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Ulcers	☐	☐
Change in bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Bleeding with bowel movements	☐	☐
Rectal Pain	☐	☐
Rectal Swelling	☐	☐
Protrusion from rectum	☐	☐
Hemorrhoids	☐	☐
Discharge	☐	☐
Crohn's Disease	☐	☐
Diverticulosis	☐	☐
Irritable Bowel Syndrome	☐	☐
Genitourinary		
Frequent Urination	☐	☐
Burning/Pain with urination	☐	☐
Blood in urine	☐	☐
Incontinence of urine	☐	☐
Bladder Infections	☐	☐
Kidney stones	☐	☐
Kidney Disease	☐	☐
Sexual difficulty	☐	☐
Male-Testicle Pain	☐	☐
Prostate Cancer	☐	☐
Female-vaginal discharge	☐	☐
Female-# of pregnancies _____		
Female-Stool through vagina	☐	☐

	No	Yes
Cardiovascular		
Chest pain	☐	☐
Shortness of breath w/walking	☐	☐
Heart Disease	☐	☐
Hypertension	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
Respiratory		
Chronic coughing	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Joint stiffness/swelling	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Difficulty in Walking	☐	☐
Arthritis	☐	☐
Integumentary (skin/breast)		
Rash or itching	☐	☐
Change in skin color	☐	☐
Varicose veins	☐	☐
Breast Pain	☐	☐
Breast lump	☐	☐
Eyes		
Wear glasses/contacts	☐	☐
Blurred or double vision	☐	☐
Eye disease/injury	☐	☐

	No	Yes
Neurological		
Frequent headaches	☐	☐
Migraine Headaches	☐	☐
Light headed/dizzy	☐	☐
Convulsion or seizures	☐	☐
Numbness or tingling sensation	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Epilepsy	☐	☐
Psychiatric		
Memory loss	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐
Ear/Nose/Mouth/Throat		
Hearing loss	☐	☐
Earaches	☐	☐
Chronic sinus problems	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Sore throat	☐	☐
Swollen glands in neck	☐	☐
Hematologic/Lymphatic		
Bleeding or bruising tendency	☐	☐
Anemia	☐	☐
Past transfusion	☐	☐
Blood Disorder	☐	☐
HIV	☐	☐
Endocrine		
Hormone problem	☐	☐
Excessive thirst or urination	☐	☐
Hyper/Hypothyroidism	☐	☐
Diabetes	☐	☐
Hepatitis	☐	☐

How often do you move your bowels? _____ per day _____ per week

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ **Date:** _____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: _____ **Date:** _____