CSS
COLORECTAL
SURGERY SERVICES

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*	**Date of Birth:**

Briefly describe your symptoms

List any medical problems that other doctors have diagnosed

List any past surgeries, colonoscopies or upper endoscopies		
Year	Reason	Hospital / Surgeon

Describe any other hospitalizations		
Year	Reason	Hospital / Physician

Please turn to next page

List your prescribed drugs and over-the-counter drugs or give your list to the nurse		
Name the drug or food	Strength	Frequency Taken

Do you have any allergies to medications? ❑ Yes ❑ No	If yes, please include any over the counter or food allergies.
Name the Drug	Reaction You Had

Please answer the following questions and check all that apply.			
Tobacco	Current every day smoker	☐ Yes	☐ No
	Current some day smoker	☐ Yes	☐ No
	Former smoker	☐ Yes	☐ No
	Never smoker	☐ Yes	☐ No
	Do you use smokeless tobacco?	☐ Yes	☐ No
Alcohol	Do you drink alcohol, beer or wine?	☐ Yes	☐ No
Drugs	Do you use street or recreational drugs	☐ Yes	☐ No

Please list any health problems in your family below.						
	AGE	SIGNIFICANT HEALTH PROBLEMS		SEX	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		☐None ☐Cancer ☐Colon cancer or colon polyps		☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps
Mother		☐None ☐Cancer ☐Colon cancer or colon polyps	**Children**	☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps
Grandmother *Maternal*		☐None ☐Cancer ☐Colon cancer or colon polyps		☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps
Grandfather *Maternal*		☐None ☐Cancer ☐Colon cancer or colon polyps	**Your siblings**	☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps
Grandmother *Paternal*		☐None ☐Cancer ☐Colon cancer or colon polyps		☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps
Grandfather *Paternal*		☐None ☐Cancer ☐Colon cancer or colon polyps		☐ M ☐ F		☐None ☐Cancer ☐Colon cancer or colon polyps

Please turn to next page

Do you have any of the following symptoms? Check the box "yes" or "no" to the right.			
General	Fevers or chills	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Poor appetite	☐ Yes	☐ No
Eyes	Visual problems	☐ Yes	☐ No
	Double vision	☐ Yes	☐ No
Ears, nose & throat	Mouth sores	☐ Yes	☐ No
	Hearing loss	☐ Yes	☐ No
Heart and blood vessels	Recurrent chest pain	☐ Yes	☐ No
	Discomfort breathing by lying flat	☐ Yes	☐ No
Lungs	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
Gastrointestinal tract or bowel	Abdominal pain	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Heartburn or indigestion	☐ Yes	☐ No
	Bleeding from rectum	☐ Yes	☐ No
	Nausea or vomiting	☐ Yes	☐ No
	Bloating or cramping	☐ Yes	☐ No
	Rectal or anal pain	☐ Yes	☐ No
	Anal leakage or incontinence	☐ Yes	☐ No
Urinary system	Stool or gas in urine stream	☐ Yes	☐ No
	Leakage of urine	☐ Yes	☐ No
Muscles and bones	Limitation of motion	☐ Yes	☐ No
	Joint or bone pain	☐ Yes	☐ No
Skin and breast	Skin rash	☐ Yes	☐ No
	Breast mass	☐ Yes	☐ No
Brain and nerves	Recurrent headaches	☐ Yes	☐ No
	Fainting or syncope	☐ Yes	☐ No
Psychiatry	Depression	☐ Yes	☐ No
	Anxiety	☐ Yes	☐ No
Endocrine and glands	Temperature intolerance	☐ Yes	☐ No
	Thyroid or other gland problems	☐ Yes	☐ No
Blood & immune system	Anemia	☐ Yes	☐ No
	Easy bruising or bleeding	☐ Yes	☐ No
	HIV positive or AIDS	☐ Yes	☐ No

Please fill this form out at home and bring it with you.

You can also fax this form to the office 2 days prior to your appointment date.

Fax number (210) 490 - 0505