



Patient Name: \_\_\_\_\_

**FAMILY HEALTH** State the age, health or cause of death in each:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Did relatives have colon cancer or polyps? ( ) No ( ) Yes: Who? \_\_\_\_\_

**SOCIAL HISTORY**

What is or was your occupation? \_\_\_\_\_

What other occupations have you had? \_\_\_\_\_

What is or was your spouse's occupation? \_\_\_\_\_

Do you have children? If yes, give their age, occupation and health problems:

Sons: \_\_\_\_\_

Daughters: \_\_\_\_\_

**PERSONAL HABITS**

Exercise: What kind? How often? \_\_\_\_\_

Cigarettes: How many? Stopped? \_\_\_\_\_

Alcohol: What kind? How much? \_\_\_\_\_

Coffee or Tea: How much? \_\_\_\_\_

Do you avoid any foods or drinks? \_\_\_\_\_

**GENERAL REVIEW**

Have you recently lost or gained weight? Yes No

Have you recently had a fever? Yes No

Do you have skin rashes or hives? Yes No

Do you have frequent headaches? Yes No

Do you have glaucoma? Yes No

Does mild exercise cause shortness of breath? Yes No

Do you get chest pain with exercise? Yes No

Do you have an irregular heart beat? Yes No

Do you have difficulty urinating? Yes No

Do you have joint or back pain? Yes No

Patient Name: \_\_\_\_\_

**GASTROINTESTINAL REVIEW**

Have you noticed a loss in appetite?	Yes	No
Have you ever been jaundiced (yellow)?	Yes	No
Do you have nausea or vomiting?	Yes	No
Do you have heartburn or acid reflux?	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you have indigestion, gas, bloating?	Yes	No
Do you have diarrhea?	Yes	No
Do you have constipation?	Yes	No
Do dairy products cause gas, diarrhea or cramping?	Yes	No
Do you pass mucus in the stool?	Yes	No
Do you pass blood in the stool?	Yes	No
Did you have a change in bowel habits?	Yes	No

**FUNCTIONAL BOWEL REVIEW**

Is the abdominal pain aggravated by meals?	Yes	No
Is the discomfort relieved with bowel motions?	Yes	No
Do you have the sense of incomplete bowel motions?	Yes	No
Do you have more bowel motions with stomach pain?	Yes	No
Are the stools looser with the onset of pain?	Yes	No
Are the stools small, thin or broken up in pieces?	Yes	No
Are symptoms worse with stress?	Yes	No

**PSYCHOSOCIAL REVIEW**

Is your mood depressed?	Yes	No
Do you have decreased pleasure or interest?	Yes	No
Do you cry easily?	Yes	No
Do you experience fatigue or loss of energy?	Yes	No
Are you an anxious person or do you worry a lot	Yes	No
Do you have trouble sleeping or getting out of bed?	Yes	No
Do you experience breathlessness?	Yes	No
Do you have palpitations or chest pain/pressure?	Yes	No
Have you seen a psychiatrist or counselor?	Yes	No