Sacramento Colon and Rectal Surgery Medical Group:

NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ AGE: _____

REASON HERE TO SEE CLINICIAN: *Please describe onset, nature and duration of symptoms*: _____
_____
_____
_____
_____

FAMILY HISTORY: *Please list family members with any types of cancer or illnesses* (i.e., *colon cancer, polyp, uterine cancer, diabetes*):_____
_____
_____
_____

SOCIAL AND PERSONAL HISTORY: *What is your occupation?* _____
_____

TOBACCO USE: *Do you smoke, chew, vape? For how many years?* _____

ALCOHOL USE: *Do you drink alcohol/liquor? If so, how many drinks per week?* ____

RECREATIONAL DRUGS: *Have you ever used or currently using, i.e., Marijuana, cocaine, etc.?* _____

PAST MEDICAL HISTORY:

PLEASE LIST ANY MEDICAL PROBLEMS: (*i.e. hypertension, diabetes, cancer, etc.*):
_____
_____
_____
_____

REVIEW OF SYMPTOMS: *Please check boxes for any that may apply*

□Fever/Chills	□Recent weight change	□Dizziness	□Difficulty hearing
□High blood pressure	□Irregular heartbeat	□Heart attack	□Cardiac catheterization
□Sleep apnea/CPAP	□Blood clots in lung	□Lung disease/COPD	□Asthma
□Breast mass/cancer	□Diarrhea	□Constipation	□Hepatitis
□Reflux/stomach ulcers	□Hernia	□Urinary frequency	□Prostate disease
□Kidney stones	□Blood in urine	□Rashes/Itching	□Change in moles
□Joint or back pain	□Arthritis	□Stroke	□Seizures
□Depression/Anxiety	□Diabetes	□Thyroid disease	□Pacemaker

MEDICATIONS: *Please list all medications and dosages currently taking* (*including nonprescription medications, such as aspirin, Motrin, etc.*) _____
_____
_____
_____
_____

ALLERGIES TO ANY MEDICATIONS, FOODS, ETC? *Please list*._____
_____
_____

PAST SURGICAL HISTORY:

Have you had any difficulty with anesthesia or bleeding during surgery? Please describe: _____
_____

Have you had a colonoscopy? Last date and findings? _____
_____
_____

Please list ALL previous operations or procedures? _____
_____
_____
_____
_____
_____
_____

ADDITONAL INFORMATION: *Do you have any other colon and rectal surgery concerns you would like to discuss with your clinician?* _____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____