

**LAHEY CLINIC DEPARTMENT OF COLON AND RECTAL SURGERY
NEW PATIENT DATA FORM**

Primary Care Dr. _____ Who referred you for this appointment _____

Age _____ Reason for this appointment: _____

Did you bring x-rays with you? Yes/No Have you had x-rays taken? Yes/ No Where/When _____

Have you had a colonoscopy/sigmoidoscopy? _____ Where/when _____

When did your colon and rectal problem start? _____ Brief history of your colorectal problem _____

Medical Problems (circle all that apply):

Heart attack/heart disease/atrial fibrillation/thyroid condition/diabetes/stroke/anemia/high blood pressure/emphysema stomach ulcers/kidney problems/liver problems/aneurysm/blood clots/cancer: type _____

Previous surgeries

Medications you take every day or week

allergies to medications

single/married/separated/divorced/widow/widower (circle) Who do you live with? _____

Do you have children? yes/no (circle) How many? _____ Ages: _____

Do you smoke? yes/no How many packs per day? _____ How many years? _____

Do you drink alcohol? Yes/no How many drinks per day/week? _____ How many years? _____

Medical history of your brothers, sisters, parents (circle all that apply)

Heart disease/high blood pressure/diabetes/cancer: type _____ stroke/arthritis/adopted

System review (circle all that apply):

General: fever/chills/runny nose/weight loss/weight gain

Central nervous system: Headache/stroke/memory loss/seizures/fainting/dizziness/numbness

Hearing: hearing loss/ringing in the ears/hearing aide

Vision: glasses/contact lenses/cataracts/glaucoma/double vision/retina problems

Heart: chest pain/palpitations/heart attack

Lungs: shortness of breath/cough/asthma/pneumonia

Digestive: heartburn/reflux/nausea/vomiting/gastritis/diarrhea/constipation/colitis

Liver: hepatitis/cirrhosis/gallstones

Urinary system: trouble urinating/burning/frequency/infections/incontinence/kidney stones

Circulation: bleeding problems/leg ulcers/peripheral vascular disease/phlebitis

Musculoskeletal: gout/fibromyalgia/osteoporosis/rheumatoid arthritis

Skin: rashes/skin cancer/psoriasis/infections

Allergies: Iodine/latex/shellfish/metal intolerance

Mental Health: depression/anxiety/mood swings/panic attacks

What is your height _____ weight _____

All other review of systems negative. Reviewed with patient -- MD signature _____