Washington University in St. Louis
School of Medicine

Section of Colon & Rectal Surgery
Washington University School of Medicine
General Health Questionnaire

Today's Date _____

Your Name _____ Date of Birth _____

PHYSICIANS

Primary Care Provider

Name _____
Address _____
City _____
State _____ ZIP _____
Phone _____

Referring Doctor

Name _____
Address _____
City _____
State _____ ZIP _____
Phone _____

List other providers who we may contact.

Name _____ Name _____
Phone _____ Phone _____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TODAY'S CONCERNS

What problem are you being seen for today? _____

_____

Are you experiencing any of the following symptoms? (check all that apply)

- ☐ Anemia
- ☐ Abdominal pain
- ☐ Blood in your stool
- ☐ Constipation
- ☐ Incontinence of stool
- ☐ Loss of appetite
- ☐ Recent weight loss
- ☐ Bright red rectal bleeding
- ☐ Perianal itching
- ☐ Rectal pain
- ☐ Nausea/vomiting
- ☐ Diarrhea

ALLERGIES

_____
_____
_____

YOUR MEDICAL HISTORY

Have you been treated for any of the following medical problems?

- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Colorectal polyps
- ☐ Colorectal cancer
- ☐ Kidney problems
- ☐ Prostate problems
- ☐ Angina
- ☐ Heart attack
- ☐ High blood pressure
- ☐ COPD/emphysema
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Gout
- ☐ Lipid disorder
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ Neuropathy
- ☐ AIDS/HIV-positive
- ☐ Hepatitis/Liver disease
- ☐ Depression
- ☐ Anxiety
- ☐ Gyn problems _____
- ☐ Other cancers _____
- ☐ Other _____

OPERATIONS If yes, check all that apply and date.

Type of Surgery	Date	Type of Surgery	Date	Type of Surgery	Date
☐ Hysterectomy	_____	☐ Appendix	_____	☐ Other _____	_____
☐ Gallbladder	_____	☐ Hernia repair	_____	☐ Other _____	_____
☐ Anorectal (for example, hemorrhoids)	_____	☐ Colonoscopy	_____	☐ Other _____	_____
		☐ Bowel surgery	_____	☐ Other _____	_____

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Number of: pregnancies_____ C-sections_____ live births_____

Did you experience any vaginal tears during delivery? ☐ Yes ☐ No

Physician's Notes

Your Name _____ Date of Birth _____

YOUR FAMILY HISTORY

Do/did any of your family members (father, mother, siblings, children) have?

			Relationship	When
☐ Colon or rectal polyps?	☐ No	☐ Yes	_____	_____
☐ Crohn's disease?	☐ No	☐ Yes	_____	_____
☐ Ulcerative colitis?	☐ No	☐ Yes	_____	_____
☐ Colon or rectal cancer?	☐ No	☐ Yes	_____	_____
☐ Other cancer?	☐ No	☐ Yes	_____	_____

PERSONAL HABITS / SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes How much? _____

Do you drink alcohol? ☐ No ☐ Yes How much? _____

Have you ever done drugs? ☐ No ☐ Yes Which ones? _____

Are you employed? ☐ No ☐ Yes Occupation _____

Marital status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Ethnicity _____

REVIEW OF SYSTEMS

Are you experiencing any of these symptoms? (check all that apply)

Chills or fevers	☐ No	☐ Yes	Spitting up blood	☐ No	☐ Yes
Weakness or fatigue	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Recent weight loss	☐ No	☐ Yes	Difficulty urinating	☐ No	☐ Yes
Loss of vision	☐ No	☐ Yes	Urinary incontinence	☐ No	☐ Yes
Diminished hearing	☐ No	☐ Yes	Bleeding problems	☐ No	☐ Yes
Light-headed or dizzy	☐ No	☐ Yes	Blood clots in legs or lungs	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Excessive thirst	☐ No	☐ Yes
Numbness or tingling	☐ No	☐ Yes	Gland or hormone problem	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes	Rash	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Joint or back pain	☐ No	☐ Yes
Irregular heartbeat	☐ No	☐ Yes	Muscle cramps	☐ No	☐ Yes
Frequent coughing	☐ No	☐ Yes	Nervousness	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	Anxiety	☐ No	☐ Yes

Physician's Notes

PLEASE SIGN BELOW AFTER COMPLETING QUESTIONNAIRE

Patient Signature _____

Reviewed by _____ MD _____

FOR PHYSICIAN USE

Gen:

CV:

Pulm:

Abd:

DRE: ☐ No masses

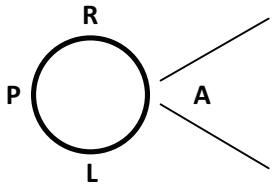
Prostate:

Anoscopy: _____

HEENT:

Rest ☐ Normal ☐ Poor

Squeeze ☐ Normal ☐ Poor



Assessment/Plan: