

Name \_\_\_\_\_

Chief Complaint \_\_\_\_\_

**PRESENT ILLNESS**

- |                              |                             |                       |                              |                             |                       |                              |                             |            |
|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pain                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Change in Bowel Habit | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diarrhea   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Fever                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Discharge             | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Itching    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Laxative Daily        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Constipation          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Protrusion |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Laxative Occasionally | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bleeding              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Swelling   |

**PAST HISTORY:**

Previous Colon or Rectal Disease \_\_\_\_\_

Previous Illness or Other Medical Problems \_\_\_\_\_

Any Previous Surgery \_\_\_\_\_

**FAMILY HISTORY:**

YES  NO Colon Polyps Who \_\_\_\_\_ Age \_\_\_\_\_

YES  NO Colon Cancer Who \_\_\_\_\_ Age \_\_\_\_\_

**ALLERGIES:**

YES  NO Penicillin  YES  NO Local Anesthesia

**MEDICINES YOU TAKE:**

\_\_\_\_\_  
\_\_\_\_\_

**FOR DOCTOR'S USE ONLY**

Initial Office Visit \_\_\_\_\_

HISTORY: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ABDOMINAL EXAM: \_\_\_\_\_

\_\_\_\_\_

**RECTAL EXAM:**

Inspection \_\_\_\_\_

Digital \_\_\_\_\_

Sigmoidoscopy \_\_\_\_\_

Anoscopy \_\_\_\_\_

Diagnosis \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_