OTTAWA HOSPITAL DEPARTMENT OF COLON AND RECTAL SURGERY
NEW PATIENT DATA FORM

Name:_____ DOB:_____

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 (circle) How many packs per day?_____ How many years?_____

Do you drink alcohol? Yes/No (circle) 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 / cartaracts / 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 _____