Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Colon and Rectal Care of Rockwall

Name: _____

DOB: _____

Date: _____

Health History Form

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Who is your Primary care Physician? _____

What is the reason for your visit? _____

Medications

Medication name	Dose and frequency

Pharmacy _____ Phone _____

Address or Cross Street _____ City _____

Allergies (foods and drugs)

Please indicate the type of reaction next to each.

_____

Past Medical History Problems (check all that apply)

__ Anemia
__ Cancer - Type: _____
__ Colitis or other bowel problem
__ Crohn's Disease
__ Gallstones
__ Hearing loss
__ Hemorrhoids
__ Hepatitis or other liver disease
__ Hernia
__ Hodgkin's disease or Leukemia
__ Hypertension
__ Jaundice
__ Diabetes
__ Migraine headaches
__ Cholesterol
__ Headaches
__ Peptic ulcer
__ Skin Problems
__ Thyroid Disorder
__ Venereal Disease
__ Other_____

Please explain any items you checked and list any medical problems not included:

_____

_____

_____

_____

Name:_____

Past Surgical History

Please list all surgeries

_____

_____

□ Yes □ No Have you had a colonoscopy? Date of last colonoscopy _____

Family Medical History

□ Negative Family History □ No knowledge of family history □ Adopted

Relation	Age	Medical Problems	If deceased, cause of death	Age of death
Father_____	_____	_____	_____	_____
Father's Father	_____	_____	_____	_____
Father's Mother				
Mother_____	_____	_____	_____	_____
Mother's Father	_____	_____	_____	_____
Mother's Mother				
Brother / Sister				
Brother / Sister				
Brother / Sister				

Diagnoses	Father	Mother	Brother	Sister	Grandfather	Grandmother
Colon Cancer	□	□	□	□	□	□
Colon Polyp	□	□	□	□	□	□
Esophageal Cancer	□	□	□	□	□	□
Stomach Cancer	□	□	□	□	□	□
Pancreatic Cancer	□	□	□	□	□	□
Peptic Ulcer Cancer	□	□	□	□	□	□
Gallbladder Disease	□	□	□	□	□	□
Gallstones	□	□	□	□	□	□
Pancreatitis	□	□	□	□	□	□
Ulcerative Colitis	□	□	□	□	□	□
Crohn's Disease	□	□	□	□	□	□
Cirrhosis	□	□	□	□	□	□
Liver Disease	□	□	□	□	□	□
Hemochromatosis	□	□	□	□	□	□
Celiac Disease	□	□	□	□	□	□
Sprue	□	□	□	□	□	□
Ovarian Cancer	□	□	□	□	□	□
Uterine Cancer	□	□	□	□	□	□
Renal Cancer	□	□	□	□	□	□
Bladder Cancer	□	□	□	□	□	□

Name: _____

Risk Factors

Tobacco/Smoking Status:

□ Current every day smoker □ Current someday smoker □ Former smoker □ Never smoker □ Smoker, current status unknown □ Unknown if ever smoked □ Heavy tobacco smoker

Alcohol Use:

Do you drink alcoholic beverages? Yes___ No___ Drinks/day_____ Type_____

Review of Systems

Do you have any of the following:

□ Yes □ No Change in skin character
□ Yes □ No Unusual grown on skin
□ Yes □ No Weight loss
□ Yes □ No Swelling or lump in neck, armpits, groin
□ Yes □ No Sudden attacks of dizziness or faintness
□ Yes □ No Frequent headaches
□ Yes □ No Bruise easily
□ Yes □ No Bleed excessively after cuts
□ Yes □ No Fever or chills
□ Yes □ No Frequent nausea or vomiting
□ Yes □ No Stomach Pain
□ Yes □ No Excessive Gas, belching or bloating
□ Yes □ No Chest Pain
□ Yes □ No Wear glasses
□ Yes □ No Shortness of Breath

□ Yes □ No Intolerance of fatty foods
□ Yes □ No Recent changes in bowel habits
□ Yes □ No Diarrhea lasting more than one week
□ Yes □ No Blood in bowel movement
□ Yes □ No Black or tarry bowel movements
□ Yes □ No Constipation
□ Yes □ No Seasonal allergies
□ Yes □ No Diabetes
□ Yes □ No Burning or pain when you urinate
□ Yes □ No Thyroid problems
□ Yes □ No Arthritis
□ Yes □ No Treatment by X-Ray or radiation
□ Yes □ No HIV
□ Yes □ No Loss of hearing - vertigo
□ Yes □ No Get up at night to urinate

Do you now have any of the following:

Men Only:

□ Yes □ No Swelling or lumps in your testicles
□ Yes □ No Prostate trouble
□ Yes □ No Discharge from penis
□ Yes □ No Sore on penis

Women Only:

□ Yes □ No Now pregnant
□ Yes □ No Unexplained vaginal bleeding
□ Yes □ No Unusual or excessive vaginal discharge
□ Yes □ No Lump in breasts

□ Yes □ No Pap Smear in last year
□ Yes □ No Menopause, if yes skip next question
□ Yes □ No Severe cramps during periods
□ Yes □ No Chronic cough

Please list any health concerns, or any other items you would like to discuss with the doctor:

_____

_____

_____