

Colon and Rectal Surgeons, Div
Review of Systems

Patient's Name: _____ Date: _____

History of Present Illness (HPI):

Past History: (PF&S)

Medical History: Please circle if you have any of these medical problems.

High Blood Pressure Diabetes Heart Trouble
Respiratory Problems Stroke Cancer
Bleeding Problems HIV/AIDS Other Problems: _____

MEDICATIONS:

List any of your current medications.

ALLERGIES:

Please list any drug, food, dye and latex allergies below. (if any)

Please Circle any surgeries you have had. (If any)

Appendix	Esophagus	Hernia	Thyroid
Aneurysm	Eye	Hip Right/Left	Tonsils
Back	Gallbladder	Knee Right/Left	Fallopian Tube (tied)
Bladder	Heart	Kidney	Hysterectomy (complete/partial)
Bowel (colon)	By pass	Lung	Vasectomy
Breast	Angioplasty	Ovary	Other: _____
Carotid Artery	Valve rep.	Prostate	_____
		Stomach	_____

FAMILY HISTORY:

Is there a family history of any of the following: (please circle)

Colon Cancer	Rectal Bleeding	Other: _____
Colon Polyps	Hypertension	_____
Ulcerative Colitis	Diabetes	_____
Cohn's Disease	Heart Attack/Stroke	_____

Social History:

Please circle

Marital Status: Single, Married, Separated, Divorced, Widowed

Occupation: _____

Tobacco Use: Never, Occasional, Quit, (when _____) Current smoker/packs per day _____

Alcohol use: Never, Occasional, Rarely, Moderate, Daily (how much) _____

Drug Use: Never Type and Frequency: _____

Sexually Transmitted disease: Yes No What Kind? _____

Colon and Rectal Surgeons, Div
Review of Systems (CON"T)

Patient's Name: _____ Date: _____

CONSTITUTIONAL:

	Yes	No
Good General Health	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats, fevers	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE:

	Yes	No
Excessive Thirst / urination	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Problem	<input type="checkbox"/>	<input type="checkbox"/>

EARS/NOSE/THROAT/MOUTH:

	Yes	No
Hearing loss or ringing	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Voice Changes	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR:

	Yes	No
Chest Pain (Angina)	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Swelling hands/feet	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY MALE:

	Yes	No
Blood in urine:	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY:

	Yes	No
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULESKELETAL:

	Yes	No
Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness/swelling joints	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones Where?	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY FEMALE:

	Yes	No
Blood in urine:	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract Infection	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL:

	Yes	No
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis/Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>

Vaginal Discharge
Is there a chance you could be pregnant ?

	Yes	No
Date of last menstrual Period _____	<input type="checkbox"/>	<input type="checkbox"/>

**HEMATOLOGIC/
LYMPHATIC**

	Yes	No
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Slow to heal	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>
Bleeds Easily	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC:

	Yes	No
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Confusion/memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mental/physical abuse	<input type="checkbox"/>	<input type="checkbox"/>

**INTEGUMENTARY
(SKIN/BREAST):**

	Yes	No
Change in hair/nails	<input type="checkbox"/>	<input type="checkbox"/>
Rashes or itching	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain/discharge	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL:

	Yes	No
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>

EYES:

	Yes	No
Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>
Blurred/double vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Injury / Injury	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blindness Right/Left	<input type="checkbox"/>	<input type="checkbox"/>
Implants Right/Left	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts Right/Left	<input type="checkbox"/>	<input type="checkbox"/>

OTHER:

	Yes	No
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (what kind)	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____