

COLON RECTAL

HEALTH CENTER OF ST. LOUIS

PATIENT MEDICAL HISTORY

PLEASE PRINT

HISTORY OF SURGERY(S) OR HOSPITALIZATIONS (PROCEDURE & YEAR):

EXISTING MEDICAL CONDITIONS:

MEDICAL HISTORY:

HAVE YOU, OR ANY MEMBERS OF YOUR FAMILY HAD ANY OF THE FOLLOWING? PLEASE PUT AN "X" IN ALL THAT APPLIES:

SELF / FAMILY MEMBER

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- ANEMIA
- BLOOD DISORDER
- HEPATITIS
- BLEEDING/BRUISING
- DIABETES
- ASTHMA
- BRONCHITIS
- EMPHYSEMA

- EPILEPSY/SEIZURES
- HAY FEVER / SINUS PROBLEMS
- HIGH CHOLESTEROL
- DEPRESSION
- EMOTIONAL PROBLEMS
- DRUG/ALCOHOL DEPENDENCY
- ARTHRITIS
- IMMUNE DISORDERS

- HEART PROBLEMS
- HIGH BLOOD PRESSURE
- STROKE
- LUNG DISEASE
- THYROID DISEASE
- KIDNEY DISEASE
- LIVER DISEASE
- SKIN DISEASE

PATIENT SOCIAL HISTORY:

ALCOHOL USE: NEVER RARELY MODERATE DAILY AMOUNT? _____/DAY

TOBACCO USE: NEVER OCCASIONALLY PREVIOUSLY QUIT DATE _____

SUBSTANCE ABUSE: NEVER YES TYPE/FREQUENCY _____

ENVIRONMENTAL EXPOSURE: DUST FUMES SOLVENTS LIST ALL _____

Patient Signature

Date

Legal Guardian if other than patient

Date

Physician Signature

Date