COLON RECTAL
HEALTH CENTER OF ST. LOUIS

CHIEF COMPLAINT:

_____

HISTORY OF PRESENT ILLNESS:

DESCRIBE THE SIGNS /SYMPTOMS THAT YOU HAVE: _____

_____

WHEN DID THE SIGNS START? _____

ARE YOU EXPERIENCING PAIN? ☐ YES ☐ NO IF YES, HOW WOULD YOU RATE YOUR PAIN, WITH 10 BEING THE WORST?

PLEASE CIRCLE: 1 2 3 4 5 6 7 8 9 10

DESCRIBE YOUR PAIN: ☐ COMES AND GOES ☐ CONSTANT ☐ OTHER (DESCRIBE) _____

MEDICAL HISTORY:

PLEASE PUT AN "X" IN THE BOX THAT APPLIES TO WHAT YOU ARE EXPERIENCING:

DAILY BOWEL MOVEMENTS	RECTAL BLEEDING	GENERAL
☐ MORE THAN ONE MOVEMENT PER DAY	☐ BRIGHT RED	☐ NAUSEA/VOMITING
☐ HARD BOWEL MOVEMENTS	☐ DARK RED	☐ DIARRHEA
☐ LOOSE BOWEL MOVEMENTS	☐ ON TOILET PAPER	☐ CONSTIPATION
☐ PAIN WITH BOWEL MOVEMENTS	☐ DRIPPING IN BOWL	☐ IMPACTED
☐ ABDOMINAL PAIN	☐ OUTSIDE OF STOOL	☐ ACID REFLUX/HEARTBURN
☐ PROTRUSION OF RECTAL TISSUE	☐ MIXED IN STOOL	☐ RECTAL ITCHING
☐ CONSTANTLY ☐ WITH BOWEL MOVEMENT	☐ RECTAL DRAINAGE	☐ LOSS OF APPETITE

MEDICAL HISTORY:

ARE YOU HIV POSITIVE? ☐ YES ☐ NO ☐ DO NOT KNOW

HAVE YOU HAD:	DATE:	RESULTS:		DATE:	RESULTS:
BARIUM ENEMA:	_____/_____		COLONOSCOPY:	_____/_____	
LOWER GI STUDY:	_____/_____		SIGMOIDOSCOPY:	_____/_____	

FAMILY HISTORY: COLON CANCER ☐ YES ☐ NO POLYPS ☐ YES ☐ NO

IF **YES**, WHICH RELATIVE AND AT WHAT AGE WERE THEY DIAGNOSED: _____

DO YOU HAVE ANY ALLERGIES TO: ☐ FOOD ☐ MEDICATIONS ☐ LATEX ☐ IODINE ☐ NO ALLERGIES

PLEASE LIST **ALLERGIES** TO MEDICATION AND REACTIONS:

/	/
/	/

MEDICATIONS:

ALL CURRENT MEDICATIONS, INCLUDING PRESCRIPTION, SUPPLEMENTS AND OVER THE COUNTER DRUGS:

_____

_____

_____ _____

Patient Signature Date

_____ _____

Legal Guardian if other than patient Physician Initials