

Colon & Rectal Surgical Consultants of North Texas  
General Health Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What are you here for today?

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Referring Physician: (name, address, phone, fax) Primary Care Physician (name, address, phone, fax)


The Program for the Elimination of Cancer Disparities (PECaD) requests the information below. The National Institutes of Health, in an effort to ensure diversity in research, requests that you report your ethnicity. Please circle all that apply, however, this section is optional:

Hispanic or Latino      Asian      African-American      Caucasian      Native Hawaiian

Native American or Alaskan Native      Pacific Islander      Other      Unknown

Medication, Dosage and Frequency Past Surgical History and Dates


Drug Allergies \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please name the drug and reactions: \_\_\_\_\_

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Any problems with anesthesia? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list reaction: \_\_\_\_\_

Health Problems:


Review of Systems:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Colon or rectal cancer? If yes, date of diagnosis _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Colon or rectal polyps? If yes, date of diagnosis _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Inflammatory bowel disease? If yes, Crohn's disease or Ulcerative Colitis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diverticular Disease? If yes, Diverticulitis _____ GI Bleed _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Colon Surgery? If yes, list surgery, reason and date _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other abdominal surgeries? If yes, list surgery, reason and date _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anal or Rectal surgery? If yes, list surgery, reason and sate _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgery in the last 30 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Received chemotherapy or radiation in the last 30 days?
		Last chemotherapy or radiation treatment? _____

Do you experience any of the following:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you gained or lost weight? Amount _____ Time _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chills or night sweats
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal appetite
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea or vomiting
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diarrhea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Constipation
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in your bowl habits
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood in your stool
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heartburn or reflux symptoms
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in swallowing
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hoarseness or change in your voice
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Persistent cough
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain at rest or exertion
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular heartbeats
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in your legs
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty urinating
<input type="checkbox"/> Yes	<input type="checkbox"/> No	On Dialysis

History of:

Yes  No Pneumonia  
 Yes  No Heart Attack? When \_\_\_\_\_  
 Yes  No Angioplasty, stents or heart surgery? When \_\_\_\_\_  
 Yes  No Blood Clots  
 Yes  No Hepatitis  
 Yes  No Jaundice  
 Yes  No Stroke? When \_\_\_\_\_  
 Yes  No Anxiety  
 Yes  No Depression  
 Yes  No Other \_\_\_\_\_

Social History:

Yes  No Do you current smoke cigarettes? Pack per day? \_\_\_\_\_  
 Yes  No Have you ever smoked? How long? \_\_\_\_\_ Year quit? \_\_\_\_\_  
 Yes  No Do you drink alcohol? Drinks per week? \_\_\_\_\_  
 Yes  No Have you ever been treated for alcoholism?  
 Yes  No Have you ever used intravenous (street) drugs? \_\_\_\_\_  
 Yes  No Are you currently employed? Occupation \_\_\_\_\_  
 Yes  No Are you married?  
 Yes  No Do you have children?  
 Yes  No Do you live alone? If yes, who is available to help you if you should need surgery? \_\_\_\_\_

Family History:

Has anyone in your family had the following conditions?

Yes  No Colon or rectal cancer? Relationship \_\_\_\_\_  
 Yes  No Inflammatory bowel disease? Relationship \_\_\_\_\_  
 Yes  No Heart Disease? Relationship \_\_\_\_\_  
 Yes  No Stroke? Relationship \_\_\_\_\_  
 Yes  No Cancer? Type \_\_\_\_\_ Relationship \_\_\_\_\_

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To be completed by medical staff:

\_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ BPM \_\_\_\_\_ / \_\_\_\_\_ Blood Pressure

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by: \_\_\_\_\_ M.D.