

Medical History

Patient _____

Family Physician _____

Height _____

Weight _____

Referring Physician _____

Do you have a medical history of the following? Yes: specify:

Eye disease _____

Recurrent nose bleeding _____

Allergies, asthma, hay fever _____

Tuberculosis _____

Pneumonia, Chronic bronchitis _____

Hypertension _____

Stroke _____

Heart attack _____

Other heart and/or vascular diseases _____

Varicosis, thrombosis, leg ulcers _____

Liver disease, gallstones _____

Upset stomach _____

Diseases of the kidney and/or bladder _____

Prostate disease _____

Diseases of the female reproductive organs _____

No. of child births __, complications? _____

Venereal diseases _____

Infectious diseases (i.e. HIV, hepatitis) _____

Skin diseases _____

Diabetes _____

Gout, rheumatism _____

Thyroid disease _____

Joint/Spine Disorders _____

Bone fractures, accidents _____

Diseases of blood and/or coagulation system _____

Cancer _____

Other diseases – if yes, please specify _____

Have you undergone surgery? _____

If yes, what type of surgery and when? _____

Do you consume alcohol regularly? _____

Do you smoke? _____

Is there a family history of cancer? _____

Do you take any medication regularly? _____

Do you take anticoagulant medication? _____

If yes, please specify _____

Current symptoms:

Please circle if appropriate:

Pain – constant, recurrent, during the day/night, before and/or during and/or after the bowel movement,

Blood - bright red, dark red, on the toilet paper, covering the stool, in the toilet bowl, before or after the bowel movement, dripping, squirting, dark black stool (melena)

Itching, Collection of pus, mucus secretion and/or moist anal region

Anal prolapse/bulges:

permanent, after straining, while walking, retracts spontaneously, has to be pushed back manually

Bowel movement and stool:

Frequency per day:

Consistency: normal, hard, soft, diarrhea, with mucus discharge

Bowel movement: normal, obstipation, frequency only every ____ days, straining necessary

Incomplete evacuation of stool, anal cramps, abdominal cramps, increased urge

Incontinence symptoms:

for flatus, liquid stools, hard stools, daily, only at night, day and night, daily, weekly, sometimes, are you impaired in your mobility and/or social contacts

Smearing of stool: never, sometimes, always,

Incontinence underwear linings/pads: never, sometimes, always

Urge for bowel movement: normal, uncertain, none

Differentiation between flatus and stool: normal, uncertain, none

Warning period before bowel movement occurs: over 1 min, less than 1 min, none

Urine incontinence: no, yes

Laxative intake: _____

Have you had prior proctological examinations?

If yes, when:

Findings/result:

Have you had a stool examination for occult blood?

If yes, when:

Findings/result:

Have you undergone a colonoscopy?

If yes, when:

Findings/result: