

MEMORIAL HERMANN Medical Group

Patient Name _____ Date of Birth _____ Date _____

Current Problem: _____ Date problem began: _____

Primary Care Physician: _____

Who referred you: _____

Past Medical History:

Please mark if YOU have a "PAST" history of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Lungs/ Respiratory Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Mental Disease |
| <input type="checkbox"/> Abnormal PSA | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis/ Diverticulosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anesthetic complications | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Reflux/ GERD |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hormone Abnormalities | <input type="checkbox"/> Stroke/ CVA |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney/ Bladder Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcerative colitis |
| | | <input type="checkbox"/> Ulcer Stomach or Duodenal |

Cancer:

- Breast Lung
 Colorectal Ovarian/Prostate
 Liver Uterine
 Skin

Pregnancy History:

- | | | | | |
|--------------------------------|-------------------------------|----------------------------|----------------------------|-----------------------------------|
| Number of Pregnancies: | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> Multiple |
| Number of Vaginal Deliveries: | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> Multiple |
| Number of Caesarean/C-section: | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> Multiple |
| Number of Episiotomies | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> Multiple |

Habits:

- | | | | |
|--------------|--|-------------------------------|----------------------------|
| Tobacco Use | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type and Amount per Day _____ | Age started smoking: _____ |
| Alcohol Use | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type and Frequency _____ | |
| Drug Use | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type and Frequency _____ | |
| Caffeine Use | <input type="checkbox"/> No <input type="checkbox"/> Yes | Type and Frequency _____ | |

Previous Colon Screening:

- | | | | | | | | |
|-------------------------|-----|----|--------------------------|-------------|----|------------|--------------|
| Flexible Sigmoidoscopy: | YES | NO | Date of last test: _____ | Polyps: YES | NO | WHEN _____ | NUMBER _____ |
| Barium Enema: | YES | NO | Date of last test: _____ | Polyps: YES | NO | WHEN _____ | NUMBER _____ |
| Colonoscopy: | YES | NO | Date of last test: _____ | Polyps: YES | NO | WHEN _____ | NUMBER _____ |

PAST SURGICAL HISTORY:

Please mark if you have a history of the following surgeries:

| | | | |
|-------------------------|--|--------------------------|---|
| Cataract: | <input type="checkbox"/> Left <input type="checkbox"/> Right | Thyroid Removal: | <input type="checkbox"/> Total <input type="checkbox"/> Partial |
| Tonsillectomy: | <input type="checkbox"/> Yes | Heart Surgery: | <input type="checkbox"/> Stents <input type="checkbox"/> Bypass <input type="checkbox"/> Valve |
| Carotid Artery Surgery: | <input type="checkbox"/> Left <input type="checkbox"/> Right | Abdominal Hernia Repair: | <input type="checkbox"/> Umbilical <input type="checkbox"/> Incisional <input type="checkbox"/> Mesh |
| Inguinal Hernia Repair: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Mesh | Appendectomy: | <input type="checkbox"/> Open <input type="checkbox"/> Laparoscopic |
| Gallbladder Surgery: | <input type="checkbox"/> Open <input type="checkbox"/> Laparoscopic | Kidney Surgery: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Kidney Stones |
| Gastric Bypass: | <input type="checkbox"/> Band <input type="checkbox"/> Laparoscopic | Lung Surgery: | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Back Surgery: | <input type="checkbox"/> Yes <input type="checkbox"/> Implant/ Prosthetic | Hip Surgery: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Implant/ Prosthetic |
| Knee Surgery: | <input type="checkbox"/> Yes <input type="checkbox"/> Right <input type="checkbox"/> Implant/ Prosthetic | Anorectal Surgery: | <input type="checkbox"/> Abscess <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Fissure |
| Colonoscopy: | <input type="checkbox"/> < 5 years <input type="checkbox"/> > 5 years | | <input type="checkbox"/> Condyloma/Warts <input type="checkbox"/> Sphincteroplasty |
| | <input type="checkbox"/> Polyps Found <input type="checkbox"/> Never had Colonoscopy | | <input type="checkbox"/> Fistula <input type="checkbox"/> Other _____ |
| Colon Surgery: | <input type="checkbox"/> Open <input type="checkbox"/> Laparoscopic <input type="checkbox"/> Right <input type="checkbox"/> Left | Rectal Surgery: | <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy |
| Breast Surgery: | <input type="checkbox"/> Benign <input type="checkbox"/> Cancer | Small Bowel Surgery: | <input type="checkbox"/> Open <input type="checkbox"/> Laparoscopic |
| D&C: | <input type="checkbox"/> Yes | Ovarian Surgery: | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Hysterectomy: | <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal | Vasectomy: | <input type="checkbox"/> Yes |
| Tubal Ligation: | <input type="checkbox"/> Yes | | |
| Other Surgery: | <input type="checkbox"/> Yes | | |

FAMILY HISTORY

(M) Mother (F) Father (G) Grandparent (B) Brother (S) Sister

| | |
|-----------------------------|---------------------------------------|
| Colon Cancer: _____ | Uterine Cancer: _____ |
| Rectal Cancer: _____ | Ovarian/Prostate Cancer: _____ |
| Polyps: _____ | Anal Canal Cancer: _____ |
| | Other: _____ |

MEDICATION/ DRUG ALLERGIES

Are you currently taking the following Medications?

Plavix (Clopidogrel) Coumadin/ Warfarin Aspirin NSAIDS None See patient provided list

What Drug Allergies Do You Have?

No drug allergies Penicillin Sulfa Iodine Codeine

Other: _____

Patient Name: _____

Date: _____

YOUR REVIEW OF SYSTEMS:

Please review the items below and mark with a “√” the symptoms you currently have:

| GENERAL | | PULMONARY/LUNG | | UROLOGIC/ REPRODUCTIVE | | NEUROLOGIC | |
|----------------------|--|------------------------------|--|------------------------|--|-----------------------|--|
| Chills/ Fever | | Productive Cough with Sputum | | Frequent Urination | | Numbness | |
| Weight Loss | | Shortness of Breath | | Blood in Urine | | Weakness | |
| Weight Gain | | Wheezing | | Urinary Incontinence | | Headaches | |
| Loss of Appetite | | None | | Difficulty Urinating | | Memory Loss | |
| None | | MUSCULOSKELETAL | | Penile Discharge | | Seizures | |
| CARDIOVASCULAR | | Back Pain | | Testicular Pain/ Mass | | Fainting or Blackouts | |
| Irregular Heartbeat | | Joint Pain | | Vaginal Discharge | | Migraines | |
| Chest Pain | | Joint Swelling | | None | | None | |
| Heart Murmur | | None | | ENDOCRINE | | EYE, EAR, AND THROAT | |
| Abnormal Heart Valve | | ABDOMINAL /GI | | Heat/Cold Intolerance | | ringing in Ears | |
| None | | Nausea/ Vomiting | | Excessive Hunger | | Hearing Problems | |
| DERMATOLOGIC | | Diarrhea | | Excessive Thirst | | Congestion | |
| Skin Rash | | Constipation | | Excessive Urination | | Dental Problems | |
| Skin Itching | | Indigestion | | Hormonal Abnormalities | | Hoarseness | |
| None | | Abdominal Pain | | None | | Difficulty Swallowing | |
| LIVER | | Bloody or Dark Stools | | ONCOLOGIC/ HEMATOLOGIC | | Recent Sore Throat | |
| Jaundice | | Incontinence of Stool | | Abnormal Bleeding | | Vision Loss | |
| None | | Mucus with Stools | | Abnormal Bruising | | Retina Problem | |
| PSYCHIATRIC | | None | | Enlarged Lymph Glands | | None | |
| Anxiety | | | | None | | | |
| Depression | | | | | | | |
| Suicidal Thoughts | | | | | | | |
| None | | | | | | | |

Patient Signature: _____

Date: _____

I have reviewed the above information with the patient on this date. All boxes which are not checked are either negative or N/A.

Physician's signature: _____

Date: _____