New Patient Questionnaire

Name: _____ Date of Birth: _____

Reason for visit (Please describe onset, nature, and duration of symptoms):_____

_____

_____

_____

On average, how often do you have a bowel movement?:____ times per day or ____ per week?

What is the average consistency?	Loose	Normal	Firm	
How often do you have blood in your stool?	Frequently	Occasionally	Rarely	Never
How often do you have pain with bowel movements?	Frequently	Occasionally	Rarely	Never
How often do you have itching?	Frequently	Occasionally	Rarely	Never
How often does extra tissue protrude out while straining?	Frequently	Occasionally	Rarely	Never

Date of last Colonoscopy: _____

Any Polyps or Cancer found? ☐ Yes ☐No Other findings? :_____

Please list **prior hospitalizations and surgeries** including approximate date and medical reason:

Date	Surgery/Hospitalization	Reason

Please check any **personal current or historical medical problems**:

☐High Blood Pressure ☐Diabetes ☐Heart Attack ☐Lung Disease/COPD

☐Sleep Apnea/OSA ☐Irregular Heartbeat ☐Cardiac Catheterization ☐Cervical Cancer

☐Reflux/GERD ☐Blood Clots ☐Pacemaker ☐Prostate Disease

☐HIV ☐Stroke ☐Hepatitis ☐Hernia

Additional Past Medical History: (Any cancers or other conditions):_____

_____

MEDICATIONS: (Please list any medications you are taking and dosages) _____

_____

_____

_____

Do you take **blood thinning** medication? ☐ No ☐ Yes _____; **Supplemental Fiber** ☐No ☐Yes

ALLERGIES: (Please list any allergies to medications or foods, etc and reaction)_____

_____

FAMILY HISTORY: Have any relatives had any of the following? ☐ Yes ☐No

If yes, please list family member (maternal/paternal) and age at diagnosis.

Colon/Rectal Cancer: _____

Polyps: _____

Cancer of the Uterus, ovaries, stomach, small bowel, liver, or genitourinary: _____

_____

Ulcerative Colitis: ☐ No ☐Yes _____; Crohn's Disease: ☐ No ☐Yes _____

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SOCIAL HISTORY:

What is or was (if retired) your **occupation**? _____

Any tobacco use? ☐Never, ☐Yes-Current, ☐Yes-Quit; If yes, Type: Smoking/Vaping/Chew

If yes, how many years did you smoke? _____

*How much did you smoke per day/week?*_____

Any alcohol use? ☐ Never, ☐Yes- Current, ☐Yes-Quit; If yes, Type: Beer/Wine/Liquor

*How many drinks do you have in a day/week/month?*_____

Any other substance use? ☐ Never, ☐Yes- Current, ☐Yes-Quit;

Type: Marijuana/THD/CBD/Cocaine/Heroin/Meth/Other(s): _____

How long ago was your last use? _____

Signature: _____ Date: _____