

LAST NAME, FIRST NAME _____

Date of Birth: _____

MedStarCRS@medstar.net



MedStar Health

Colon & Rectal Surgery Patient Registration Form

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Primary Phone Okay to leave voicemail <input type="checkbox"/> Yes <input type="checkbox"/> No		Secondary Phone	
Email Address			
Gender (biological) <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Language	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner	Employment Status Occupation: _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed/Disability	Race <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	
Emergency Contact			
First Name	Last Name	Relationship	
Phone Number			
Which doctor sent you to us? <input type="checkbox"/> I'm self-referred		Name (first last)	
Specialty	Phone #	Fax #	
Address	City	State	Zip
Who is your primary care physician <input type="checkbox"/> None		Name (first last)	
Specialty	Phone #	Fax #	
Address	City	State	Zip
Any other physicians we should contact?		Name (first last)	
Specialty	Phone #	Fax #	
Address	City	State	Zip
		Name (first last)	
Specialty	Phone #	Fax #	
Address	City	State	Zip
What is your preferred pharmacy? <input type="checkbox"/> None		Name	
4 - digit code	Phone #	Fax #	
Address (or Street)	City	State	Zip

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What brings you in today? _____

Medications (including over the counter):

Name	Dose	Frequency	Date Started

Allergies (please describe reaction): No known allergies

Past/Current Medical Problems: None

Past Surgical History: None

Family History: None

Any family with colon or rectal cancer? No Yes
Any family with colon or rectal polyps? No Yes
Any family with crohn's or colitis? No Yes
Any family history of uterine cancer? No Yes

Family member relationship to you

Social History:

Alcohol Use: No Yes _____ # of drinks/day
Smoking History: No Yes _____ # of packs/day Date Quit _____ Current Smoker
Recreational Drugs: No Yes name of drug(s) _____

Date of last colonoscopy: _____ None Findings: _____
Name of doctor who did your last colonoscopy _____



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Review of Systems: Do you have or have you had any problems with the following systems?

General

- Fever No Yes
- Poor appetite or weight loss No Yes

Breast

- Nipple discharge No Yes
- Breast pain No Yes
- Breast enlargement No Yes

Cardiac

- History of heart attack No Yes
- Any heart procedures No Yes
- Chest pain No Yes
- Palpitations No Yes
- Syncope No Yes
- Peripheral edema No Yes

Respiratory

- Cough No Yes
- Shortness of breath No Yes
- Wheezing No Yes

Vascular

- Any varicose veins No Yes
- Pain in legs with walking No Yes
- Resting leg pain No Yes
- Pain at night in legs No Yes

Genitals

- Issues with your vagina/penis No Yes
- Genital warts No Yes
- Anal warts No Yes
- If yes, with dysplasia No Yes

Genitourinary

- Painful urination No Yes
- Blood in urine No Yes
- Frequency No Yes
- Urinary hesitancy or urgency No Yes
- Increase urination at night No Yes
- Incontinence No Yes
- Erectile dysfunction No Yes

Skin

- New skin lesions No Yes
- Changes in mole(s) No Yes
- Rash No Yes
- History of skin cancer No Yes

Neurologic

- Paralysis No Yes
- Paresthesias No Yes
- Seizures No Yes
- Frequent headaches No Yes
- Memory Loss No Yes

Psychiatric

- Depression No Yes
- Suicidal Ideation No Yes
- Anxiety No Yes

Lymphatic

- Abnormal bruising or bleeding No Yes
- Any enlarged lymph nodes No Yes

Musculoskeletal

- Do you have any back pain, sciatica or arthritis No Yes

Gastrointestinal

- Anal or rectal bleeding No Yes
- Change in bowel habits No Yes
- Diarrhea No Yes
- Constipation No Yes
- Anal pain No Yes
- Anal lump No Yes
- Anal itching No Yes
- Abdominal pain No Yes
- Straining with bowel movement No Yes

How often do you have a BM _____

Have you ever been tested for HIV? No Yes, Date of last test _____ Negative Positive

If positive: Name of HIV doctor _____

Date of latest labs drawn _____ CD4 count _____ Viral load _____

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Do you have any fecal incontinence? No Yes
(inability to control bowel movement)

If Yes Only: Cleveland Clinic Incontinence Score

Please tick one box in each row to indicate on average how often you experience the following:

	Never	Rarely Less than once a month	Sometimes Less than once a week	Usually Less than once a day	Always Everyday
a. Solid stool leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Liquid stool leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Gas leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Pad use (for stool)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lifestyle restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female Patients: Obstetric/Gynecologic History

Of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Of Vaginal Births: _____ # Of C-Sections: _____ Date of last menstrual period _____