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 ❑ Yes ❑ No	Secondary Phone		
Email Address			
Gender (biological) ❑ M ❑ F	Gender Identity ❑ M ❑ F	Preferred Language	
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner	Employment Status Occupation: _____ ❑ Full-time ❑ Part-time ❑ Retired ❑ Student ❑ Unemployed/Disability	Race ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other	

Emergency Contact			
First Name	Last Name	Relationship	
Phone Number			

Which doctor sent you to us? ❑ I'm self-referred		Name (first last)	
Specialty		Phone #	Fax #
Address	City	State	Zip

Who is your primary care physician ❑ 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? ❑ 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

			Family member relationship to you
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	_____

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 vericose 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	❑	❑	❑	❑	❑
b. Liquid stool leakage	❑	❑	❑	❑	❑
c. Gas leakage	❑	❑	❑	❑	❑
d. Pad use (for stool)	❑	❑	❑	❑	❑
e. Lifestyle restriction	❑	❑	❑	❑	❑

Female Patients: Obstetric/Gyncologic History

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

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