



KENDRICK REGIONAL CENTER FOR COLON AND RECTAL CARE
Specialists in colon and rectal surgery and general surgery

Olaf B. Johansen, M.D.

Barry Melbert, M.D.

Frederick R. Lane, M.D.

Bridget Sanders, M.D.

Dipen C. Maun, M.D.

Ben Tsai, M.D.

DATE: _____

NAME- FIRST: _____ M.I.: _____ LAST: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE: () _____ CELL PHONE: () _____

MALE: _____ FEMALE: _____ MARITAL STATUS: _____

BIRTHDATE: _____ AGE: _____ SS#: _____

EMPLOYER: _____ WORK PHONE _____

OCCUPATION: _____

SPOUSES NAME: _____ BIRTHDATE: _____

SS#: _____ EMPLOYER: _____ WORK PHONE: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: () _____

PERSON TO CONTACT IN AN EMERGENCY (other than living in your home) _____

RELATIONSHIP TO PATIENT: _____ PHONE: () _____

LIST IN ORDER NAMES OF YOUR INSURANCE COMPANIES: (we also require a copy of your insurance cards-front and back for billing purposes)

COMPANY NAME	POLICY HOLDER	MEMBER #	GROUP #
1. _____	_____	_____	_____
2. _____	_____	_____	_____

INSURANCE POLICY HOLDERS NAME: _____

DATE OF BIRTH : _____ SOCIAL SECURITY NUMBER: _____

WERE YOU REFERRED TO US? YES: _____ NO: _____ BY WHOM? DOCTOR: _____ FRIEND: _____ RELATIVE: _____

IF YOU WERE NOT REFERRED, HOW DID YOU HEAR ABOUT US? _____

NAME OF REFERRING DOCTOR: _____

ADDRESS OF REFERRING DOCTOR: _____

LIST FAMILY DOCTOR (IF OTHER THAN REFERRING DOCTOR) NAME: _____

ADDRESS: _____

ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay my physician at Kendrick Regional Center directly for any benefits due me under the terms of my policy issued by your company. I will be responsible for the remaining deductibles, co-payments or balances due. I also authorize release of information acquired during my examination and treatment to the insurance company to facilitate payment.

SIGN HERE: _____
(patient or guardian if minor)

HEALTH HISTORY DATA SHEET

Patient Name _____ Today's Date _____

WEIGHT: _____ HEIGHT: _____

History of Present Illness/Symptoms

Within the last year have you had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood with bowel movement | <input type="checkbox"/> Constipation | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Loose or frequent stools | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Black tarry stools | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Abdominal bloating/cramping |
| <input type="checkbox"/> Other _____ | | |

Gastrointestinal

- Colon cancer or polyps
- Ulcerative colitis
- Crohn's disease
- Inflammatory bowel disease

Other

Other cancer: Location _____

AIDS/HIV positive

Pacemaker or Implanted Defibrillator : Type _____ Please provide card for copying.

Surgical History *Please list surgical procedures you have had and approximately what year:*

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Gallbladder removed | <input type="checkbox"/> Cardiac stents | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Cesarean section | <input type="checkbox"/> _____ |

Have you ever had:

- | | |
|---|--------------------------|
| <input type="checkbox"/> Colonoscopy | If yes, what year: _____ |
| <input type="checkbox"/> Flexible sigmoidoscopy | If yes, what year: _____ |
| <input type="checkbox"/> Barium enema | If yes, what year: _____ |

Medications (use back of page if additional space needed) Separate list provided

Please list medication, dosage, and frequency (include herbal medications):

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Are you taking any blood thinners, such as Coumadin or Plavix? Aspirin, Advil, Aleve, etc.?

Have you taken Prednisone or Cortisone in the last three months?

Medication Allergies

Please list any allergies to medications: NONE LATEX ALLERGY

1. _____ 2. _____ 3. _____

Social History

Do you smoke? Yes No Packs per day: _____ Number of years smoked: _____ What year did you quit? _____
Do you drink alcohol on a regular basis? Yes No If yes, how much per day? _____
What is your occupation? _____

Family History Please check if your relatives have had:

- Colon cancer – Relationship _____ Colon polyps - Relationship _____
- Ulcerative colitis Crohn’s disease Familial Polyposis
- Other types of cancer Type of cancer _____ Relationship _____

Review of Systems

Please mark if you have ever had:

Constitutional

- Persistent fever, chills
- Weight loss or gain
- Fatigue

Eyes

- Blurry or double vision
- Wear glasses or contacts
- Glaucoma

Ear, Nose, Mouth, Throat

- Hearing loss or ringing
- Ear aches
- Nose bleeding
- Mouth sores
- Sore throat
- Swollen glands in neck

Cardiovascular

- Chest pain
- Heart murmur
- Palpitations
- Irregular heart beat
- Swelling of hands or feet
- Shortness of breath with walking

Integumentary

- Rash or itching
- Skin problems
- Breast pain, lump, or discharge

Respiratory

- Shortness of breath
- Wheezing
- Chronic cough
- Spitting up blood

Gastrointestinal

- Abdominal pain
- Nausea or vomiting
- Diarrhea
- Loss of appetite
- Blood in stool
- Painful bowel movements
- Change in stools

Genitourinary

- Frequent urination
- Painful urination
- Blood in urine
- Urinary incontinence
- Abnormal periods
- Kidney problems

Musculoskeletal

- Joint pain
- Joint swelling
- Muscle weakness
- Back pain

Neurological

- Frequent headaches
- Lightheadedness or dizziness
- Convulsions or seizures

Psychiatric

- Depression
- Anxiety
- Hallucinations
- Memory problems

Endocrine

- Glandular or hormone problem
- Thyroid disease
- Heat or cold intolerance
- Excessive thirst or urination

Allergic/Immunologic

- Adverse reaction to antibiotics
- Adverse reaction to narcotics
- Adverse reaction to anesthetics

Hematologic/Lymphatic

- Abnormal bleeding with surgery
- Blood disorder
- Anemia
- Blood clots in legs or lungs

DATE COMPLETED _____ PATIENT SIGNATURE _____

I reviewed the health history form. M.D. SIGNATURE _____ DATE _____

I updated the health history form. M.D. SIGNATURE _____ DATE _____

I updated the health history form. M.D. SIGNATURE _____ DATE _____