



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

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DATE: _____

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

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

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

MALE: _____ FEMALE: _____ MARITAL STATUS: _____

BIRTHDATE: _____ AGE: _____ SS#: _____

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: _____

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: () _____

INSURANCE POLICY HOLDERS NAME: _____

DATE OF BIRTH : _____ SOCIAL SECURITY NUMBER: _____

LIST IN ORDER NAMES OF YOUR INSURANCE COMPANIES: (or provide them for copying)

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

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

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)

CURRENT PROBLEM

- Abdominal pain
- Colon cancer
- Colon cancer screening
- Constipation
- Diarrhea
- Gallbladder
- Hemorrhoids
- Hernia
- Incontinence of feces
- Nausea/vomiting
- Rectal bleeding
- Rectal pain
- Other

ILLNESSES

- AIDS/HIV positive
- Asthma/emphysema /COPD
- Coronary artery disease
- Diabetes
- Gastroesophageal reflux
- Hypertension
- Kidney disease
- Seizure disorder
- Stroke
- Other

REVIEW OF SYSTEMS

- Fever
- Weight loss
- Chest pain
- Palpitations
- Short of breath
- Cough
- Incontinence, urinary
- Headaches
- Depression
- Sleep disturbance
- Easy bruising
- Blood clots
- Bleeding disorders
- Other

List any previous surgeries/procedures: _____

What is your height? _____ Weight? _____

List any medications, including herbal supplements, you are now taking:

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

Use back of page if additional space is needed

Drug Allergies Yes No If Yes, please list _____

Latex Allergy Yes No

Do you use the following?

Tobacco Yes No If yes, packs per day _____ for _____ years.

Alcohol Yes No If yes, drinks per day _____/week _____.

Have you ever had a colonoscopy? Yes No If yes, what year: _____

Have you ever had a flexible sigmoidoscopy? Yes No If yes, what year: _____

Have you ever had a barium enema? Yes No If yes, what year: _____

FAMILY HISTORY

Has a family member had any of the following? If so, check the appropriate box.

	Father	Mother	Children	Brothers/ Sisters	Grandparents
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M.D. Signature _____ **Date** _____

Follow-up visit review

No change in above _____ M.D. Signature _____ Date _____

Changes noted and initialed by M.D. M.D. Signature _____ Date _____

Follow-up visit review

No change in above _____ M.D. Signature _____ Date _____

Changes noted and initialed by M.D. M.D. Signature _____ Date _____