Colon & Rectal Surgical Consultants of North Texas
General Health Questionnaire

Date: _____

Name: _____ Date of Birth: _____

What are you here for today?

_____

_____

_____

Referring Provider: (name, address, phone, fax)	Primary Care Provider: (name, address, phone, fax)

The Program for the Elimination of Cancer Disparities (PECaD) requests the information below. The National Institutes of Health, in an effort to ensure diversity in research, requests that you report your ethnicity. Please circle all that apply, however, this section is optional:

Hispanic or Latino Asian African-American Caucasian Native Hawaiian

Native American or Alaskan Native Pacific Islander Other Unknown

Medication, Dosage and Frequency	Past Surgical History and Dates

Drug Allergies _____Yes _____No
If yes, please name the drug and reactions:_____

_____

Any problems with anesthesia? _____Yes _____No

If yes, please list reaction: _____

Health Problems:

Have you had any of the following?

_____Yes _____No Prior colonoscopy? If yes, date _____

_____Yes _____No Colon or rectal cancer? If yes, date of diagnosis_____

_____Yes _____No Colon or rectal polyps? If yes, date of diagnosis_____

_____Yes _____No Inflammatory bowel disease? If yes, Crohn's disease_____ Ulcerative Colitis_____

_____Yes _____No Diverticular Disease? If yes, Diverticulitis _____ GI Bleed _____

_____Yes _____No Colon Surgery? If yes, list surgery, reason and date _____
_____

_____Yes _____No Other abdominal surgeries? If yes, list surgery, reason and date_____
_____

_____Yes _____No Anal or Rectal surgery? If yes, list surgery, reason and date_____
_____

_____Yes _____No Surgery in the last 30 days? _____

_____Yes _____No Received chemotherapy or radiation in the last 30 days?

Do you experience any of the following?

_____Yes _____No Have you gained or lost weight? Amount _____ Time _____

_____Yes _____No Chills or night sweats

_____Yes _____No Abnormal appetite

_____Yes _____No Nausea or vomiting

_____Yes _____No Diarrhea

_____Yes _____No Constipation

_____Yes _____No Pain with bowel movements

_____Yes _____No Change in your bowel habits

_____Yes _____No Blood in your stool or bleeding with bowel movements

_____Yes _____No Heartburn or reflux symptoms

_____Yes _____No Difficulty in swallowing

_____Yes _____No Hoarseness or change in your voice

_____Yes _____No Shortness of breath

_____Yes _____No Persistent cough

_____Yes _____No Chest pain at rest or exertion

_____Yes _____No Irregular heartbeats

_____Yes _____No Swelling in your legs

_____Yes _____No Difficulty or pain with urination

Medical History:

_____Yes _____No Pneumonia
_____Yes _____No Heart Attack? When _____
_____Yes _____No Angioplasty, stents or heart surgery? When _____
_____Yes _____No Anemia
_____Yes _____No Blood Clots
_____Yes _____No Blood Thinners? Type_____
_____Yes _____No Hepatitis
_____Yes _____No Jaundice
_____Yes _____No Dialysis
_____Yes _____No Stroke? When _____
_____Yes _____No Anxiety
_____Yes _____No Depression
_____Yes _____No Sleep Apnea? CPAP_____ BIPAP_____
_____Yes _____No Other _____

Social History:

_____Yes _____No Do you currently smoke cigarettes or use smokeless tobacco (e.g. vaping or e-cigarettes)? Packs per day? _____
_____Yes _____No Have you ever smoked? How long? _____ Year quit? _____
_____Yes _____No Do you drink alcohol? Drinks per week? _____
_____Yes _____No Have you ever been treated for alcoholism?
_____Yes _____No Have you ever used recreational (street) drugs? _____
_____Yes _____No Are you currently employed? Occupation _____
_____Yes _____No Are you married?
_____Yes _____No Do you have children?
_____Yes _____No Do you live alone? If yes, who is available to help you if you should need surgery? _____

Has anyone in your family had the following conditions?

_____Yes _____No Colon or rectal cancer? Relationship _____
_____Yes _____No Inflammatory bowel disease? Relationship _____
_____Yes _____No Heart Disease? Relationship _____
_____Yes _____No Stroke? Relationship _____
_____Yes _____No Cancer? Type _____Relationship_____

Reviewed by: _____M.D./PA-C