DR. JEREMY SPRINGER
GENERAL & COLORECTAL SURGERY
MD MSc FRCSC
568 Christina St N. Entrance B, Lower Level
Sarnia, Ontario | N7T 5W6
Phone: (519) 344-3371
Fax: (519) 344-3365

Medical History Form

Please read carefully and complete the following medical history as best as possible

(Confidential once completed)

Name: _____ Age: _____ Date: _____

Referring Doctor: _____ Primary Care Doctor: _____

Reason for today's visit: _____

Medical History

Check **significant** complaints below. Circle answers when appropriate.

1. ____ **Rectal Bleeding?** For how long? _____
   ___ bright red ___ black, tarry ___ with bowel movements
   ___ on toilet paper ___ into toilet bowel ___ mixed with stool
2. ____ **Rectal Pain?** ___ constant ___ increasing
   ___ sporadic ___ with bowel movements
3. ____ **Rectal Swelling/Protrusion?** For how long? _____ with bowel movements? YES/NO
   ___ you must push back in OR ___ spontaneously reduces
4. ____ **Incontinence to gas or stool** (Do you have uncontrollable accidents?) YES/NO If so, how often? _____
5. Have you had a recent change in bowel habits? YES/NO ___ Diarrhea ___ Constipation ___Narrow stool
   Other rectal concerns? _____
   ___ Itching ___ Drainage ___ Mucous ___ Mass ___Warts
6. Number of bowel movements per day: _____
7. Do you strain when you have a bowel movement? YES/NO
8. Do you spend greater than 10-15 minutes on the toilet to have a bowel movement? YES/NO
9. Do you feel satisfied that you have emptied following a bowel movement? YES/NO
10. Do you regularly use a laxatives or fiber supplement? YES/NO If yes, what?: _____
11. Other abdominal concerns? _____
    ___ Abdominal Pain (Location_____) ___ Cramping ___ Bloating
    ___ nausea ___ vomiting _____heart burn
    ____pain with swallowing ___difficulty swallowing ____regurgitation
12. Previous colonoscopy? YES/NO If yes, when and where?_____
13. Previous FIT or FOBT YES/NO If yes, when?_____
14. Any recent involuntary weight loss? YES/NO. If yes, how much/over what period of time? _____
15. Any fevers or chills? YES/NO

16. Any eye swelling, new skin rashes or abnormal joint pain? YES/NO

Past Medical History

Have you ever been diagnosed with?					
Colon Polyps	Yes	No	High Cholesterol	Yes	No
Colorectal Cancer	Yes	No	Stroke	Yes	No
Diverticulitis/Diverticulosis	Yes	No	Thyroid Problems	Yes	No
Crohn's Disease	Yes	No	Liver Disease	Yes	No
Ulcerative Colitis	Yes	No	Bleeding Problems	Yes	No
Irritable Bowel	Yes	No	Blood Clots	Yes	No
Hemorrhoids	Yes	No	Kidney/renal disease	Yes	No
Anal Fissure	Yes	No	Anemia	Yes	No
Rectal Abscess	Yes	No	Reflux Disease	Yes	No
High Blood Pressure	Yes	No	Emphysema/COPD	Yes	No
Heart Trouble	Yes	No	Asthma	Yes	No
Heart Attack	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Other Cancer	Yes	No
			HIV	Yes	No

Any other medical problems which you have been diagnosed with or take medication for? _____

Past Surgical History

List any surgeries you have had and the dates:

_____ _____
_____ _____
_____ _____

Medications

List all medications you take and doses:

_____ _____
_____ _____
_____ _____
_____ _____

Allergies

Do you have any drug allergies? Yes No Are you allergic to latex? Yes No
If yes, what drugs and reaction?: _____

Family History

Mother: ___Living ___Deceased Cause?_____
Father: ___Living ___Deceased Cause?_____
#Siblings: ___Living ___Deceased Cause?_____

Has any family member had the following?

___ Colon Polyps	__ Parent	__ Sibling	__ grandparent/aunt/uncle/cousin
___ Colon Cancer	__ Parent	__ Sibling	__ grandparent/aunt/uncle/cousin
___ Ulcerative Colitis	__ Parent	__ Sibling	__ grandparent/aunt/uncle/cousin
___ Crohn's Disease	__ Parent	__ Sibling	__ grandparent/aunt/uncle/cousin

Other diseases check all that apply:

__ Endometrial cancer	__ Ovarian cancer	__ Cardiac disease	__ Bleeding disorder
__ Breast Cancer	__ Stomach cancer	__Stroke	__ Diabetes

Other: _____

Social History

Do you smoke?	Yes	No	If yes, how many packs per day?_____
Do you drink alcohol?	Yes	No	If yes, how much? _____
Do you use illicit drugs?	Yes	No	If yes, what drugs? _____
Are you employed?	Yes	No	Occupation_____
Are you retired?	Yes	No	Who do you live with?_____

Review of symptoms Circle ALL that CURRENTLY apply:

Genitourinary

Dysuria/painful urination
Frequency
Hematuria/Blood in urine
Stool in urine
Urinary incontinence

Female:
# of pregnancies: ____
# of vaginal deliveries: ____
# of c-sections: ____
Obstetrical Injuries?____