SOUTH FLORIDA COLORECTAL INSTITUTE
ELIE SCHOCHET, M.D.

PATIENT HISTORY FORM

Patient Name: _____

What type of complaint or disease is the reason for requesting this visit?

_____

Habits: Do you smoke? No_____Yes_____ If yes, how many packs per day? _____
If you have quit, how long ago? _____

Do you use alcohol? No_____Yes_____ If yes, how often do you drink? _____
If you have quit, how long ago? _____

Do you use marijuana? No_____Yes_____ If yes, how often? _____
If you have quit, how long ago? _____

PAST MEDICAL HISTORY:

Please list other diseases/conditions from which you **currently** suffer:

_____

_____

Please list other medical conditions from which you have suffered **in the past**:

_____

_____

Please list any surgeries (operations), reason for the surgery, and date of surgery:

_____

_____

_____

_____

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MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

_____
_____

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your **blood relatives**

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

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SYMPTOM REVIEW (Check all that apply)

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather

Women only
- ☐ abnormal cervical Pap smear
- ☐ bleeding between periods

date of last mammogram_____

Men only
- ☐ PSA
- ☐ abnormal anal Pap smear

Other
_____

Immunizations: If YES, give approximate year given

Flu	No_____	Yes_____
Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
HPV	No_____	Yes_____

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

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