Date_____ **New Patient History and ROS** **Tufts Medical Center**

Bruce A. Orkin, M.D.

Chief, Division of Colon and Rectal Surgery
borkin@tuftsmedicalcenter.org

800 Washington Street, #6190
Boston, MA 02111
T 617-636-6190
F 617-636-9095
Tuftsmedicalcenter.org

Medical History and Review of Symptoms - New patient

Name **Vital Signs:** **Ht**_____**Wt**_____**BMI**_____
MRN
DOB **HR**_____**RR**_____**BP**_____**Pain**_____

Please complete the form below before your visit. Check boxes ☐ or circle symptoms you have.

Primary care doctor_____ Who referred you_____

Other doctors _____

Chief Complaint?_____

_____

Have you ever had a colonoscopy, upper endoscopy (EGD) or had a recent CT scan, ultrasound, PET scan?

Study_____Date_____Findings_____

Study_____Date_____Findings_____

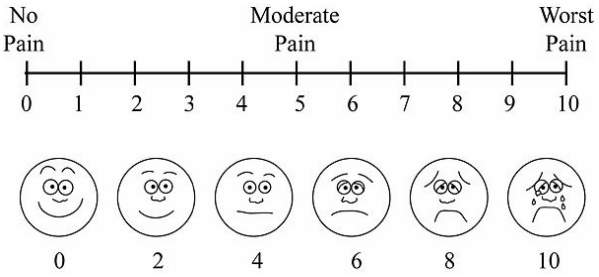
Study_____Date_____Findings_____

Study_____Date_____Findings_____

Do you have any of the following? If so, check the box and describe.

General - ☐ Nothing in this group
Weight – ☐ overweight / ☐ underweight / ☐ just right
Recent weight change – ☐ gain / ☐ loss ____lb / kg
Over how long? _____ months / years
☐ Malnutrition
☐ Loss of appetite
☐ Heat intolerance / ☐ Cold intolerance
☐ Fever
☐ Chills
☐ Thirst
☐ Sweats – ☐ day / ☐ night
☐ Fainting spells
☐ Poor healing
☐ Birth defects _____

Pain – location _____



Anal and rectal symptoms - ☐ Nothing in this group
☐ Pain – ☐ sharp / ☐ dull / ☐ burning.
☐ Rectal Bleeding – ☐ on the paper / ☐ in the water / ☐ coating or streaking the stool / ☐ mixed in the stool
☐ Prolapsing or protruding tissue - ☐ goes in by itself / ☐ push back in
☐ Anal or rectal masses, age/date/how long _____
☐ Abscess, age/date/how long _____, ☐ drained on its own, ☐ lanced
☐ Fistula, age/date/how long _____
☐ Hemorrhoids – ☐ internal / ☐ external / ☐ skin tags/ ☐ not sure, for how long? _____

Bowel Habits – Number of BMs per day / week _____ Easy / Straining; Hard / Soft / Loose / Watery

Allergies ☐ None; ☐ Latex; ☐ Iodine; ☐ Intravenous contrast
☐ Yes ☐ No Medications – ☐ Penicillin, ☐ Sulfa meds, other _____
☐ Yes ☐ No Environment – food, pollens, animals _____
☐ Yes ☐ No Anesthesia complications_____

Gastrointestinal - ☐ Nothing in this group
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Bleeding with BMs
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal prolapse
- ☐ Loss of control – solid stool / liquid / gas / urgency / soiling
- ☐ Constipation – how long ?_____
- ☐ Irritable bowel syndrome - IBS – diarrhea / constipation / both
- ☐ Pseudo-obstruction / dysmotility
- ☐ Proctalgia fugax / levator syndrome

- ☐ Colon / rectal - cancer / polyps
- ☐ Ulcerative colitis – rectum / left colon / total colon / dysplasia
- ☐ Crohn's disease – small bowel / colon / rectum / anus
- ☐ Diverticulosis / Diverticulitis
- ☐ Fatty liver / NASH
- ☐ Hepatitis – A / B /C
- ☐ Cirrhosis
- ☐ Liver nodule / cyst / cancer

Head and Neck - ☐ Nothing in this group
- ☐ Vision changes
- ☐ Runny nose/cold/sinus problems
- ☐ Sore throat
- ☐ Mouth lesions/ulcers
- ☐ Ear ache/infection
- ☐ Hearing changes
- ☐ Neck stiffness/pain
- ☐ Enlarged neck glands/masses

Cardiovascular - ☐ Nothing in this group
- ☐ Chest pain – ☐ with activity, ☐ at rest
- ☐ Ankle / leg swelling
- ☐ Coronary artery disease
- ☐ Prior heart attack, age/date _____
- ☐ Palpitations / fast heart rate
- ☐ Congestive heart failure
- ☐ Cardiomegaly – enlarged heart
- ☐ Dysrhythmia - atrial fib / SVT / PAT / flutter
- ☐ Valve disease / ☐ Murmur_____
- ☐ High blood pressure, ☐ Low blood pressure
- ☐ High cholesterol

Respiratory - ☐ Nothing in this group
- ☐ Shortness of breath – ☐ with activity, ☐ at rest
- ☐ Cough
- ☐ Wheezing
- ☐ Asthma – childhood – ☐ resolved, ☐ persistent; adult - ☐ exercise-induced, ☐ cough variant, ☐ allergic
- ☐ Bronchitis – acute, chronic
- ☐ Pneumonia, age/date _____
- ☐ Obstructive lung disease (COPD)
- ☐ Emphysema
- ☐ Chronic respiratory failure, ☐ Home oxygen
- ☐ Lung nodule / cancer, age/date _____
- ☐ Sleep apnea

Endocrine - ☐ Nothing in this group
- ☐ Diabetes – ☐ Type 1 childhood / ☐ Type 2 adult
  - ☐ Neuropathy/nerves, ☐ Nephropathy/kidneys,
  - ☐ Retinopathy/eyes, ☐ Vascular/blood flow
- ☐ Hyperthyroid / ☐ hypothyroid / ☐ Nodule / ☐ Cancer
- ☐ Pituitary disorder _____
- ☐ Adrenal disorder _____
- ☐ Pancreas – ☐ Pancreatitis / ☐ Cyst, / ☐ Cancer

Hematologic - ☐ Nothing in this group
- ☐ Swollen lumps in the groin or armpits
- ☐ Easy bruising
- ☐ Bleeding - shaving or brushing teeth, ☐ nosebleeds
- ☐ Blood clots - ☐ Deep vein thrombosis–DVT
  - ☐ Pulmonary embolism – PE
- ☐ Blood thinners use – List in medications
- ☐ Bleeding disorder – von Willebrand's / Factor V Leiden / antiphospholipid antibodies / low platelets
  Other _____
- ☐ Leukemia / ☐ Lymphoma, age/date _____
- ☐ Prior transfusions, ☐ Reaction

Urinary/Kidneys/Gyn - ☐ Nothing in this group
- ☐ Kidney stones
- ☐ Renal-kidney failure – ☐ acute / ☐ chronic
- ☐ Pain / ☐ Burning / ☐ Blood with urination
- ☐ Difficult urination
- ☐ UTI – infection
- ☐ Urinary incontinence

Men
- ☐ Nocturia, urinate ___ times per night
- ☐ BPH – prostate hypertrophy
- ☐ Prostate cancer, age/date _____
- ☐ Swelling / lump testicles (balls) or scrotum
- ☐ Penile discharge
- ☐ Erection problem

Women
- ☐ Periods abnormal – ☐ none, ☐ irregular, ☐ painful
- ☐ Breast ☐ lump/ ☐ discharge/ ☐ cancer, age/date____
- ☐ Pain with intercourse
- ☐ Vaginal discharge
- ☐ Vaginal prolapse / bulging / ☐ Uterine prolapse
- ☐ Rectocele / ☐ Enterocele / ☐ Cystocele

Musculoskeletal - ☐ Nothing in this group
- ☐ Fractures, breaks _____
- ☐ Back pain
- ☐ Accidents, trauma _____
- ☐ Leg pain – ☐ walking / ☐ at rest
- ☐ Joint pain _____
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Degenerative joint disease
- ☐ Other_____

Skin - ☐ Nothing in this group
- ☐ Itching
- ☐ Rash _____
- ☐ Eczema
- ☐ Abscess, where _____
- ☐ Psoriasis
- ☐ Other _____

☐ paralysis /☐ dyslexia / ☐ other

Neurologic - ☐ Nothing in this group
- ☐ Dizziness
- ☐ Muscle weakness – location_____
- ☐ Paralysis – level _____
- ☐ Numbness – location_____
- ☐ Headaches – ☐ Migraines/ ☐ Vascular/ ☐ Tension
- ☐ Memory loss
- ☐ Seizures – ☐ Childhood - ☐ febrile
  ☐ Adult - ☐ grand mal / ☐ petite mal / ☐ other
- ☐ Stroke – ☐ resolved / ☐ persistent;

Psychiatric - ☐ Nothing in this group
- ☐ Depression
- ☐ Delusions / ☐ Hallucinations / ☐ Hearing voices
- ☐ Anxiety / Panic attacks
- ☐ Phobias - Afraid of _____
- ☐ Suicidal thoughts / ☐ Attempts ____
- ☐ Schizophrenia
- ☐ OCD – obsessive compulsive disorder
- ☐ Bipolar disorder / ☐ Mood swings
- ☐ Personality disorder

Infections - ☐ Nothing in this group
- ☐ Current cold / flu /other infection
- ☐ HIV infection, ☐ Not tested; CD4____, viral load_____,Complications _____
- ☐ TB – tuberculosis infection, ☐ Not tested; Treated – ☐ Yes ☐ No – Date _____
- ☐ Other sexual transmitted disease – STD _____

Past Surgeries – ☐ None
- ☐ Appendectomy – Year/age _____
- ☐ Cholecystectomy – gallbladder – Year/age _____
- ☐ Hernia repair – Year/age ___Type_____
- ☐ Hysterectomy, ovaries ☐ in ☐ out – Year/age _____

Women
- Number of pregnancies
- Live births _____
- Miscarriages _____
- Abortions _____
- Having periods? ☐ Yes ☐ No

Others – Date/age ***Procedure***

_____ _____
_____ _____
_____ _____

Medications: *Name, dose, frequency* – ☐ None

_____ _____
_____ _____
_____ _____
_____ _____

Social History

Marital Status – ☐ Single, never married / ☐ Married / ☐ Partner / ☐ Divorced / ☐ Separated

Sexual orientation – ☐ Heterosexual / ☐ Homosexual / ☐ Bisexual / ☐ Other _____

☐ Yes ☐ No Children – *Age, gender*_____
☐ Yes ☐ No Grandchildren – Number ____
☐ Yes ☐ No Alcohol – Number of drinks per day / week_____, types of drinks_____
☐ Yes ☐ No Smoking – packs per day_____for _____years
☐ Yes ☐ No Drug use – ☐ current, ☐ past _____

Born – City and state_____ Living in – City and state_____

Occupation – _____Working / Retired / Disability

Family History **Who?**
- ☐ Cancer – colon or rectum
- ☐ Cancer – breast
- ☐ Cancer – uterine or ovarian
- ☐ Cancer – prostate
- ☐ Cancer – other _____
- ☐ Colon polyps
- ☐ Ulcerative colitis

Who?
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ Bleeding disorder
- ☐ Anesthesia complications
- ☐ Other / genetic_____

Signed_____Date_____