Colon & Rectal SURGICAL ASSOCIATES of Birmingham, PC

Name (Last, First MI): _____ DOB: _____

Address: _____

Home phone: _____ Cell phone: _____

Social Security Number: _____ Email: _____

Sex: _____ Marital Status: _____ Sexual Orientation: _____

Race: _____ Ethnicity: _____ Preferred language: _____

Occupation: _____

Primary Insurance Company: _____ Subscriber name: _____

Subscriber DOB: _____ Last 4 Subscriber SSN: _____ Subscriber relationship to patient: _____

Secondary Insurance Company: _____ Subscriber name: _____

Subscriber DOB: _____ Last 4 Subscriber SSN: _____ Subscriber relationship to patient: _____

Tertiary Insurance Company: _____ Subscriber name: _____

Subscriber DOB: _____ Last 4 Subscriber SSN: _____ Subscriber relationship to patient: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Please provide our office with all insurance cards and driver's license or other form of identification at the time of your appointment.

MEDICAL HISTORY

***** Please complete all sections leaving no blanks. *****

List all medical conditions: **□ Check here for no medical problems**

List all prior surgeries: **□ Check here for no prior surgery**

List any drugs allergies you have and reaction: **□ Check here for no drug allergies**

List all your medications including over the counter: **□ Check here for no medications**

List all your doctors first and last name and specialty starting with primary care:

Please list any medical conditions in your immediate family (parents, siblings, or children): **□ Check here for no family history**

Last colonoscopy: _____ **Doctor:** _____ **Location:** _____

□ Check here if you have never had a colonoscopy.

- Are you on blood thinners? If yes, please list the name and the reason. _____
  _____
- Are you on any immunosuppressant medications (Methotrexate, Humira, prednisone, etc.)? If yes, please list the name and the reason and date of last dose. _____
- Have you ever had a HIV + diagnosis? _____
- What pharmacy do you use? _____ Location? _____ Phone #: _____
- Have you had a flu shot in the last year? _____ Date: _____
- Have you had a pneumonia vaccine? _____
- Do you use tobacco products? If yes, how much and what? _____
- Do you drink alcohol? If yes, how much and what type? _____
- Do you use illicit drugs? If yes, what? _____

Please check all that apply:

GENERAL	SKIN	HEAD/NECK	HEART	LUNGS	URINARY	MUSCULOSKELETAL	NEURO	HEMATOLOGIC
Fever	Rash	Headache	Chest pain	Cough	Frequency	Muscle or joint pain	Fainting	Easy bruising
Chills	Sores	Swollen glands	Short of breath	Wheezing	Painful voiding	Weakness	Numbness	Easy bleeding
Weight loss (_____ lbs)			Palpitations	Short of breath	Urgency	Frequent falls	Tremors	Clotting problems
Weight gain (_____ lbs)								
Fatigue								
Swelling/Edema								

GASTROINTESTINAL	Anorectal bleeding	Anorectal pain	Anorectal itching/burning	Nausea	Vomiting	Constipation	Diarrhea
Change in bowel habits	Fecal incontinence	Blood in stool	Left lower abdominal pain	Left upper abdominal pain	Right lower abdominal pain	Right upper abdominal pain	Decreased appetite

Briefly state why you are being seen today: _____

_____

Signature: _____ Date: _____