

Associated Colon and Rectal Surgeons  
 3900 park Ave, Suite 101  
 Edison, NJ 08820

PLEASE BE SURE TO CIRCLE YES OR NO WHEN SPECIFIED  
 AND DO NOT LEAVE ANYTHING BLANK

DOB - \_\_\_\_\_ AGE- \_\_\_\_\_

<b>Height:</b>				<b>History</b>	
<b>Weight:</b>					
<b>Reason For Visit:</b>				<b>Review of System: Are you experiencing any problems regarding:</b>	
<b>Current Medications and Dosage</b>					
				<b>NEUROLOGIC</b>	
				Dizziness	
				Y / N	
				Light-Headedness	
				Y / N	
				Fainting	
				Y / N	
				Weakness	
				Y / N	
				<b>CARDIAC</b>	
				Chest Pain	
				Y / N	
				Pressure	
				Y / N	
				Tightness	
				Y / N	
				Squeezing	
				Y / N	
				Palpitations	
				Y / N	
				Angina	
				Y / N	
				<b>RESPIRATORY</b>	
				Shortness of Breath	
				Y / N	
				Coughing	
				Y / N	
				Fevers	
				Y / N	
				<b>GASTRO- INTESTINAL</b>	
				Nausea	
				Y / N	
				Vomiting	
				Y / N	
				Vomiting Blood	
				Y / N	
				Diarrhea	
				Y / N	
				Abdominal Pain	
				Y / N	
				Weight Loss	
				Y / N	
				<b>URINARY TRACT</b>	
				Burning w/ Urination	
				Y / N	
				Frequent Urination	
				Y / N	
				Inability to Urinate	
				Y / N	
				Urinating at Night	
				Y / N	
				<b>MUSCULO- SKELETAL</b>	
				Leg Swelling	
				Y / N	
				Joint Swelling	
				Y / N	
				Inflammation of Joints	
				Y / N	
				Pain while Walking	
				Y / N	
				<b>SKIN RASHES:</b>	
<b>Surgical History / Operations</b>				<b>DATE</b>	
<b>Social History</b>				<b>COMMENTS:</b>	
TOBACCO					
Y / N					
Packs per day?					
Years?					
ALCOHOL					
Y / N					
Drinks per day?					
Years?					
Allergies to medications, X-ray dyes, etc.					
If yes please list:					
<b>Do you take Antibiotics Before Any Dental or Surgical Procedures?</b>				<b>PRINT NAME</b>	
Y / N					
(such as Amoxicillin or Erythromycin)					
If YES please explain:				<b>PATIENT SIGNATURE &amp; DATE</b>	
				<b>PHYSICIAN SIGNATURE</b>	