SUSAN C BRILEY, M.D.
Patient History Form

NAME: ______________________________________ DATE: __________________ AGE: ___________

Referring Physician: _____________________________ Primary Care Physician: ___________________________

What is your reason for today's visit? ____

When did this problem start? ____________________ Where is this problem located? _________________________

What makes this problem worse? ____

Current Symptoms (please check any you are experiencing)

Abdominal pain　Vomiting　Anorectal Pain　Protrusion
Nausea　Change in Bowel Habits　Itching
Weight Loss　€Rectal Bleeding　Leakage

Other Symptoms: ____

Previous Surgery (of any kind) ____

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Previous Colonoscopy: ____________________________________ Results: ______________________________

Previous Hospitalizations: ____

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Radiation Treatment: ______________________________________ Pregnancies: __________________________

Height ________________ Weight ___________________

Medical Conditions: (**Please check all that apply**)

Heart Disease　Diabetes　Stroke　Hepatitis　High Blood Pressure　Asthma　HIV
Cancer type: ____

Other Conditions: ____

Medicines and Doses (including aspirin/laxatives): ____

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Allergies, ____

Family History: (**Please check if you have a father, mother, sister or brother with**):

Colon Rectal Cancer　Ovarian/Uterine Cancer　Breast Cancer　Heart Disease
Ulcerative Colitis　Crohn's Disease　Stroke　Diabetes
Bleeding Problems　Other: ____

Social History: Occupation: ____

Tobacco: Yes No Amount: ___________ Alcohol: Yes No Amount: ___________