PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

COLON & RECTAL HEALTH HISTORY FORM

Patient Name: _____ Today's Date: _____

Reason for today's visit: _____

Do you have any rectal pain? _____☐Yes ☐ No
Do you have any abdominal pain? _____☐Yes ☐ No
Do you have any rectal bleeding? _____☐Yes ☐ No
What is the color of the bleeding? _____☐Bright red ☐Dark red ☐Maroon☐ Black
How many bowel movements per day ☐1 ☐2 ☐3 ☐4 ☐5 ☐≥6 or per week ☐6 ☐5 ☐4 ☐3 ☐2 ☐≤1
What are your bowel movements like? _____☐Loose ☐Soft ☐Hard
Has the diameter of the stools changed? _____☐Yes ☐ No
How long do you sit to move your bowels? _____☐ 5 minutes ☐ 10 minutes ☐30 minutes ☐ >30 minutes
Do you have diarrhea? _____ ☐Yes ☐ No
Do you have constipation? _____☐Yes ☐ No
Do you have swelling around the anal area? _____☐Yes ☐ No
Have you noticed lumps or bumps coming out of your anus? _____☐Yes ☐ No
Do you have discharge from your anus (e.g. mucous or pus)? _____☐Yes ☐ No
Do you have to hurry to the bathroom to avoid an accident? _____☐Yes ☐ No
Do you have any leakage of stool? _____☐Yes ☐ No
Do you ever leak any urine? _____☐Yes ☐ No
Do you use laxatives to have bowel movements? _____☐Yes-Type? _____ ☐ No
Do you have any family history of colon/rectal/ovarian/endometrial cancer? _____☐Yes ☐ No
Relationship: _____ Age: _____
Relationship: _____ Age: _____

Please check the box if you have ever been diagnosed with:

☐ Colorectal adenomatous polyps
☐ Crohn's disease
☐ Ulcerative colitis
☐ Familial adenomatous polyposis
☐ Hereditary nonpolyposis colon cancer (HNPCC)
☐ Gardner Syndrome
☐ Breast cancer

Please check the box if you have ever had:

☐ Colon/Rectal/ Anal surgery
☐ Colonoscopy
☐ Barium enema

Water intake: (check all that apply)

☐ < 4 glasses/day ☐ 4-8 glasses/day ☐ > 8 glasses/day

Do you drink more than 14 alcoholic beverages per week? _____ ☐Yes ☐ No
Do you get at least 30 minutes of moderate exercise on most days? _____ ☐ Yes ☐ No