EYVAZZADEH & REILLY COLON AND RECTAL CENTER
406 DELAWARE AVENUE • BETHLEHEM, PENNSYLVANIA 18015
(610) 866-2600 • FAX (610) 861-7640 • www.ercrc.com

IN ORDER FOR THE DOCTOR TO PERFORM A THOROUGH EVALUATION IN A TIMELY MANNER, IT IS EXTREMELY IMPORTANT THAT ALL SECTIONS OF THIS FORM BE FULLY COMPLETED IF APPLICABLE.

ON THE DAY OF YOUR APPOINTMENT, PLEASE BRING YOUR INSURANCE CARD AND A VALID PHOTO ID.

Patient Name _____ DOB_____

Family Physician _____ Pharmacy _____

PAST MEDICAL HISTORY

HISTORY OF:	DETAILS:
❑ Cancer	
❑ Cardiovascular	
❑ Ears/Nose/Throat	
❑ Gastrointestinal	
Have you ever had a colonoscopy? Date: _____ Polyps? ❑ Yes ❑ No	
❑ Musculoskeletal	
❑ Endocrine	
❑ Respiratory	
❑ Genitourinary	
Females: Pregnancy(s) _____ Vaginal Deliveries _____ Cesarean _____	
❑ Psych/Social/Neu	
❑ Other:	

SURGICAL HISTORY

SURGERY:	DETAILS:
❑ Cardiac	
❑ Ears/Nose/Throat	
❑ Lung	
❑ Musculoskeletal	
❑ Gastrointestinal	
❑ Genitourinary	
❑ GYN	
❑ Other:	

FAMILY MEDICAL HISTORY

FAMILY MEDICAL HISTORY OF:	DETAILS:
❑ Cancer	
❑ Ulcerative Colitis	
❑ Crohn's Disease	
❑ Heart Disease	
❑ Diabetes/Renal	
❑ Respiratory	
❑ Psych/Social	
❑ Other:	

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No ❑ Former Smoker	( ) packs per day	
Do you drink alcohol? ❑ Yes ❑ No	( ) drinks per day	
Do you drink caffeinated beverages? ❑ Yes ❑ No	( ) cups per day	
Do you exercise? ❑ Yes ❑ No	( ) times per week	
Have you ever experienced a reaction to anesthesia? ❑ Yes ❑ No	Explain:	

CURRENT MEDICATIONS AND DOSAGE (INCLUDING ASPIRIN)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PLEASE COMPLETE REVERSE

ALLERGIES & REACTION (INCLUDE FOOD/DRUG/ENVIRONMENTAL)

ALLERGY:	DESCRIPTION OF REACTION:

Have you recently had:

Mammogram? ❑ no ❑ yes PAP Smear? ❑ no ❑ yes Dexa Scan? ❑ no ❑ yes Urinary Incontinence? ❑ no ❑ yes

Influenza (Flu) Vaccine? ❑ no ❑ yes if yes, date (if known) _____

Pneumococcal (Pneumonia) Vaccine? ❑ no ❑ yes if yes, date (if known) _____

Place an "X" beside those conditions which affect you.

	GENERAL
	Fevers
	Chills
	Sweats
	Fatigue
	Unexpected Weight Loss
	Weakness
	Other:

	EYES
	Blurring
	Double Vision
	Irritation
	Discharge
	Vision Loss
	Eye Pain
	Intolerance to Light
	Blindness
	Other:

	EARS/NOSE/THROAT
	Earache
	Ear Discharge
	Ringing in Ears
	Decreased Hearing
	Nasal Congestion
	Nosebleeds
	Sore Throat
	Hoarseness
	Difficulty Swallowing
	Nasal Discharge
	Other:

	CARDIOVASCULAR
	Chest Pains
	Palpitations
	Fainting
	Swollen Ankles
	Other:

	RESPIRATORY
	Cough
	Difficulty Breathing
	Excessive Sputum
	Spitting Up Blood
	Wheezing
	Shortness of Breath
	Awakening Short of Breath
	Cannot Breathe When Lying Flat
	Cough Up Blood
	Painful Breathing
	Other:

	GASTROINTESTINAL
	Nausea
	Vomiting
	Diarrhea
	Constipation
	Change in Bowel Habits
	Abdominal Pain
	Stool w/Bright Red Blood
	Tarry Bowel Movements
	Anal Itching
	Anal Burning
	Anal Pain
	Vomit Blood
	Frequent Heartburn
	Heartburn Awakens You
	Rectal Bleeding
	Loss of Bowel Control/Soiling
	Unpredictable Bowel Habits
	Other:

	GENITOURINARY
	Discharge
	Urinary Hesitancy
	Incontinence
	Genital Sores
	Urgent Urination
	Frequent Urination
	Urination During the Night
	Blood in Urine
	Painful Urination
	Leakage of Urine
	Pelvic Pain
	Other:

	MEN ONLY:
	Erection Difficulties
	Impotence
	Other:

	WOMEN ONLY:
	Planning Pregnancy
	Nipple Discharge
	Lump in Breast
	Vaginal Discharge
	Non-Menstrual Bleeding
	Painful Intercourse
	Decreased Libido
	Other:

	MUSCULOSKELETAL
	Back Pain
	Joint Pain
	Joint Swelling
	Muscle Cramps
	Muscle Weakness
	Stiffness
	Arthritis
	Other:

	SKIN
	Rash
	Itching
	Dryness
	Suspicious Lesions
	Other:

	NEUROLOGIC
	Weakness
	Seizures
	Tremors
	Dizziness
	Fainting
	Other:

	PSYCHIATRIC
	Depression
	Anxiety
	Memory Loss
	Mental Disturbance
	Suicidal Ideation
	Hallucinations
	Sudden Agitation
	Lethargy
	Other:

	ENDOCRINE
	Cold Intolerance
	Heat Intolerance
	Eating Abnormal Amounts of Food
	Excessive Urination
	Weight Change
	Flushing
	Swollen Glands
	Excessive Thirst
	Other:

	HEME/LYMPHATIC
	Abnormal Bruising
	Bleeding
	Other:

	ALLERGIC/IMMUNOLOGIC
	Sudden Eruption of Blisters
	Persistent Infections
	HIV Exposure
	Severe Itching/Hives
	Other:

DATE _____

Signature of Patient