Section of Colon & Rectal Surgery
Washington University School of Medicine
General Health Questionnaire

Date: _____

Name:_____ **Date of Birth:** _____

What are you here for today? _____

_____

_____

Referring Physician: (name, address, phone)	**Primary Care Physician: (name, address, phone, fax)**
Please list anyone else that we may release medical information to	

Height: _____ **Weight:** _____

The Program for the Elimination of Cancer Disparities (PECaD) requests the information below. The National Institutes of Health, in an effort to ensure diversity in research, requests that you report your ethnicity. Please mark all that apply, however this section is optional:

□ Hispanic or Latino □ Asian □ African-American □ Caucasian □ Native Hawaiian

□ Native American or Alaskan Native □ Pacific Islander □ Other □ Unknown

Medications
Please list your current medications and dosages:

Drug Allergies
☐Yes ☐No Do you have any drug allergies?
If yes, please name the drugs and reactions:

_____

_____

Have you had:

☐Yes ☐No Colon or rectal cancer—if yes, date of diagnosis _____.
☐Yes ☐No Colon or rectal polyps—if yes, date of diagnosis _____.
☐Yes ☐ No Inflammatory bowel disease—if yes, Crohn's disease or Ulcerative colitis)
☐Yes ☐No Diverticular disease—if yes, Diverticulitis _____GI bleed _____ Diverticulosis_____
☐Yes ☐No Colon surgery--list surgery, reason for surgery & date

_____

☐Yes ☐No Other abdominal surgeries—list surgery, reason for surgery & date_____

_____

☐Yes ☐No Anal or rectal surgery—list surgery, reason for surgery & date_____

☐Yes ☐No Recent fevers
☐Yes ☐No Recent unintentional weight loss
☐Yes ☐No Previous organ transplant
☐Yes ☐No HIV related illness

☐Yes ☐No Iritis (inflammation of the eyes)
☐Yes ☐No Blindness
☐Yes ☐No Ulcers in the mouth

☐Yes ☐No Chest pain
☐Yes ☐No Heart attack
☐Yes ☐No Irregular heart beat
☐Yes ☐No Pacemaker
☐Yes ☐No Heart surgery
☐Yes ☐No Hypertension (High blood pressure)
☐Yes ☐No Stroke
☐Yes ☐No Poor blood flow to the legs
☐Yes ☐No Blood clot in the legs
☐Yes ☐No Blood clot in the lungs

☐Yes ☐No Asthma
☐Yes ☐No Emphysema
☐Yes ☐No Pneumonia
☐Yes ☐No Tuberculosis

☐Yes ☐No Kidney failure / dialysis
☐Yes ☐No Urinary or prostate problems
☐Yes ☐No Impotence
☐Yes ☐No Diabetes
☐Yes ☐No Thyroid problems
☐Yes ☐No Steroids (Prednisone, etc.) by mouth (if yes, for what reason_____)
☐Yes ☐No Arthritis

☐Yes ☐No Neurologic illness (multiple sclerosis, Parkinson's, etc.)
☐Yes ☐No Psychiatric illness (if yes, diagnosis _____)

☐Yes ☐No Blood transfusion (if yes, date of transfusion _____)
☐Yes ☐No History of bleeding problems
☐Yes ☐No Anemia (low blood count)
☐Yes ☐No Blood thinners, Aspirin, arthritis medication, Vitamin E, herbal remedies, or non-steroidal anti-inflammatory drugs (ibuprofen, etc.) within the last 7 days?

☐Yes ☐No Gallbladder disease or gallstones
☐Yes ☐No Liver disease or cirrhosis
☐Yes ☐No Ulcer of the stomach or duodenum (small intestine)
☐Yes ☐No Gastritis (inflammation of the stomach)
☐Yes ☐No Diseases of the Pancreas

☐Yes ☐No Have you had any diagnosis of illness or cancer that has not been previously mentioned? (If yes, please list:_____)

☐Yes ☐No Do you smoke cigarettes currently? (if yes, how many packs/day _____)
☐Yes ☐No Have you ever smoked? If yes, how many years did you smoke?_____
When did you quit smoking? _____
☐Yes ☐No Do you drink alcohol? if yes, how many drinks/week_____)
☐Yes ☐No Have you ever been treated for alcoholism?
☐Yes ☐No Have you ever used intravenous (street) drugs?

☐Yes ☐No Are you currently employed? Occupation_____
☐Yes ☐No Are you married?
☐Yes ☐No Do you have children?
☐Yes ☐No Do you live alone? If yes, who is available to help should you need surgery?_____

Family History

Has anyone in your **family** had the following conditions?

☐Yes ☐No Colon or rectal cancer
☐Yes ☐No Inflammatory bowel disease (Crohn's disease or ulcerative colitis)
☐Yes ☐No Heart disease
☐Yes ☐No Stroke

☐Yes ☐No Do you have a relative (parents, siblings, grandparents, aunts, uncles, cousins) with a history of cancer (colon or rectal, uterus, ovary, stomach, small intestine, kidney, bladder, ureter, bile ducts, pancreas or brain)

If yes, please specify

Relation to Patient	Cancer Site	Age at Diagnosis

Please sign below after completing the questionnaire:

Patient signature: _____

Reviewed by:_____, R.N. _____, M.D.

Revised 12-15-11