Benrus Surgical
at Barnes Jewish St. Peters

Patient History
Dr. Miller Patients

ALL QUESTIONS MUST BE ANSWERED

Name: _____ Age:_____ Date:_____ DOB: _____
What is your primary problem? How long has it been going on? _____
_____
Who is your Primary Care Doctor: _____ Referring Doctor: _____
Please indicate if you have had any of the following:

Rectal pain	Y/N	Constipation	Y/N
Rectal bleeding	Y/N	Diarrhea	Y/N
Itching/Burning	Y/N	Blood in Stool	Y/N
Protrusion/Swelling	Y/N	Change in bowel habits	Y/N
Discharge	Y/N	Fecal Incontinence	Y/N
Abdominal Pain	Y/N	Diverticulosis	Y/N
Nausea	Y/N	Vomiting	Y/N

Have you had a Colonoscopy? _____ When?/Where?_____
How often do you move your bowels? _____
Do you need to take antibiotics before surgical or dental procedures? Why?_____
Have you ever been treated for the following: Chlamydia: Y/N Gonorrhea: Y/N
Syphilis: Y/N Venereal Warts: Y/N Herpes: Y/N HIV/AIDS: Y/N Hepatitis: Y/N
Have you ever received Radiation Therapy or Radiation Seeds for any reason such as prostate cancer or Cervical cancer? Explain? Y/N _____

Current Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies (meds, Latex)

_____
_____
_____
_____
_____

Social History: Tobacco Y/N Amount? _____
Alcohol Y/N Amount? _____

Surgical History

_____
_____
_____
_____
_____

Medical/Family History:
(Do you or your family have any of the following problems?)

	Patient	Family
Colon Cancer	____	____
Colon Polyps	____	____
Ulcerative Colitis	____	____
Crohns disease	____	____
Other cancers	____	____
Heart Disease	____	____
Hypertension	____	____
Diabetes	____	____
Stroke	____	____
Lung Disease	____	____
Liver Disease	____	____
Kidney Disease	____	____
Blood clotting problems	____	____

Physician Signature_____

Review of Systems

General	Weight loss	Y/N
	Sleep Apnea	Y/N
Neurologic	Dizziness	Y/N
	Light-headed	Y/N
	Weakness	Y/N
Eyes	Vision changes	Y/N
ENT	Hearing changes	Y/N
Cardiac	Chest Pain	Y/N
	Chest pressure	Y/N
	Tightness	Y/N
	Palpitations	Y/N
Respiratory	Shortness of Breath	Y/N
	Coughing	Y/N
	Wheezing	Y/N
Urinary tract	Frequent urination	Y/N
	Burning	Y/N
	Inability to urinate	Y/N
Musculoskeletal	Leg swelling	Y/N
Lymph	Swollen glands	Y/N
Hematologic	Easy bruising	Y/N
Skin	Rashes	Y/N