



SET II

1. Normally, how often do you move your bowels? _____

2. Is your stool:

- | | | |
|----------------------------------|---------------------------------|--|
| <input type="checkbox"/> hard | <input type="checkbox"/> thin | <input type="checkbox"/> small pellets |
| <input type="checkbox"/> loose | <input type="checkbox"/> watery | <input type="checkbox"/> bloody |
| <input type="checkbox"/> mucousy | | |

3. Do you have pain or cramping:

- before a bowel movement
- with a bowel movement
- after a bowel movement

4. Does pain, cramping or urgency to move your bowels awaken you from sleep? _____

5. Are you presently under increased stress due to personal or financial problems? _____

6. Indicate recent:

- weight gain weight loss #lbs.

7. Are symptoms:

- caused by eating
- relieved by eating
- no change with eating

8. Check any of the following foods which affect your bowel habits:

- | | |
|---|--|
| <input type="checkbox"/> dairy products | <input type="checkbox"/> spicy |
| <input type="checkbox"/> coffee/tea | <input type="checkbox"/> greasy |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> high fiber foods |
| <input type="checkbox"/> vegetables | <input type="checkbox"/> other (specify) _____ |

9. Have you ever noticed blood:

- mixed with stool
- on the surface of the water
- on the toilet tissue

How often? _____ For how long? _____

10. Do you have hemorrhoids? _____



If you have diarrhea or rectal bleeding, please complete the following:

1. Have you ever traveled away from home and developed a severe case of diarrhea? _____

If yes, when and where? _____

2. Have you recently been in contact with anyone with diarrhea or dysentery? _____

3. Have you ever been treated for worms or parasites? _____

If yes, when and where? _____

4. Have you recently finished taking antibiotics? _____ No _____ Yes

Which antibiotic? _____ When did you finish it? _____

5. Do you regularly take antacid medications such as Maalox, Mylanta, etc? _____ No _____ Yes

If yes, which one? _____

6. Do you engage in homosexual activity or anal intercourse? _____

7. Have you recently had any of the following?

_____ fevers

_____ sweats

_____ chills

_____ flushing

_____ skin rashes

_____ mouth sores

_____ joint pain/swelling

_____ back pain

_____ blood in urine

_____ pain/burning on urination



Social History

Tobacco Use

Cigarettes Never Quit/Date _____ Current Smoker: packs/day _____ # years _____
Other tobacco Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? Yes No # drinks per week _____
Is your alcohol intake a concern to you or others? Yes No

Drug Use

Do you use any recreational drugs? Yes No Name of Drug(s) _____
Is your alcohol intake a concern to you or others? Yes No

Sexual Activity

Sexually active? Yes No Not Currently
Current ex partner(s) is/are Male Female

Caffeine Intake

Coffee Tea Soda _____ cups/glasses per day

Safety

Do you use seatbelts consistently? Yes No
Is violence at home a concern for you? Yes No

Do you have a living will or a durable power of attorney for health care? Yes No

Patient communication / Learner Assessment

1. When learning new information about your health, do you have any difficulty because of the following:

- I cannot hear well I cannot see well
- I do not speak English well I cannot read English well
- I have trouble remembering things No difficulties
- other, please specify: _____

2. If there is someone needed to help you (e.g. act as an interpreter), please name that person:

_____ Relationship to you: _____

If you need an interpreter please specify the language needed: _____

3. How do prefer to learn?

- Written instructions Oral instructions Demonstrations

4. Do you have religious or cultural beliefs you want us to consider when we are planning your care:

- Yes No

5. Can we leave messages regarding your health?

At your home: Yes No Telephone#: () _____ - _____
 At work: Yes No Telephone#: () _____ - _____
 On a cell phone: Yes No Telephone#: () _____ - _____

6. Do you prefer to communicate through electronic mail (e-mail)? Yes No



Signature of the patient _____ Date _____

Source (if other than patient) _____ Signature of the person acquiring this information _____

May we leave a message for the results on your voice mail? _____ Yes _____ No

I hereby acknowledge that I received a copy of Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Patient Name: _____ Date: _____