

COLORECTAL PHYSICIANS & SURGEONS OF PENNSYLVANIA

145 West 23 Street, Suite 201
Erie, Pennsylvania 16502
814/453-2777 Fax: 814/453-2779

Philip D. Kondylis, MD, FACS, FASCRS
Patrick J. Recio, DO, FACS, FASCRS



PLEASE READ CAREFULLY AND COMPLETE FULLY

Name _____

Date of Birth _____ Gender _____

Primary Care Doctor _____

Referring Doctor _____

Reason for this visit: _____

Current Symptoms: _____

When did this start? _____

Have you had this problem before No Yes If Yes, when _____

Prior Treatments: _____

Rectal Bleeding: (Check) card test/microscopic on toilet paper in toilet bowl with clots

Appearance: (Check) Bright red dark red mixed with stool With discharge with pus

Rectal Pain: (Check) constant with bowel movements worsening sporadic spasming

with bowel movements after bowel movements wakes you from a sound sleep

Rectal Swelling: No Yes If Yes, explain _____

Hemorrhoids Falling Out: No Yes If Yes, explain _____

Causing Fecal Incontinence: No Yes If Yes, explain _____

Abdominal Pain: If Yes, check: cramping bloating constant worsening sporadic

associated with meals associated with bowel movements

Diarrhea: If Yes, check: loose watery mucus blood How long _____

Number of stools per day: 1 2 3 4 5 6 or more

Constipation: If Yes, check: infrequent stools straining/difficulty hard stools How long _____

Number of stools per week: 6 5 4 3 2 1 less than one

Previous treatments attempted: high fiber diet "natural" laxatives (herbal tea, senna, cascara)

- stool softeners (Surfax, Colace) stimulant laxatives (ex-lax, Dulcolax, Doxidan)
 fiber supplements (Metamucil, Citrucel, Fibersure, Benefiber, Konsyl) Other _____

Medical preparation was used: Preparation H. Anusol ProctoFoam Tuks wipes

Normal Bowel Habit Hx:

Stools/day _____ Stools/week _____

Current Diet: high-fiber (more than 6 fruits/vegetables per day) high-fiber cereal (Fiber One, All Bran)
 other cereals diabetic diet avoiding nuts, seeds, corn, etc.

Beverages: coffee tea cola beverages chocolate

Water Intake: less than 4 glasses per day 4-8 glasses per day more than 8 glasses per day

Long-term laxative Use:

Stool Softeners (Colace) No Yes

Stimulants (Dulcolax/Ex-Lax) No Yes

Fiber Supplements No Yes

“Natural” (Herb tea/Senna/Cascara/Aloe/Rhubarb/Acai) No Yes

How Often Used _____ How Many Years _____

Past Medical History:

Please mark all that apply

Weight Loss	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Rectal Bleeding	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Fatigue	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Bowel Polyps	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Stomach ulcers	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Anal Fissures	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Acid Reflux	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Anal Fistulas	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Diabetes	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Endometriosis	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Hepatitis	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Prior Pregnancy	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Seizures/Epilepsy	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Rectocele	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Stroke/TIA	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Enterocele	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Blood Vessel Disease	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Pelvic Organ Prolapse	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Anxiety	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Asthma	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Depression	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Emphysema/COPD	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Thyroid Disease	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Tuberculosis	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Anemia	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Sleep Apnea	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Bleeding Problems	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Heart Attack	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Blood Clots	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Congestive Heart Failure	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Arthritis	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Cardiac Rhythm Disorder	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Irritable/Spastic Bowel	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Urinary Incontinence	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Ulcerative Colitis	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Renal Failure/Dialysis	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Crohn’s Disease	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Stool Urgency/Leakage	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Colon Cancer	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Difficulty with Anesthesia	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Rectal Cancer	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Chemotherapy	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Other Cancer	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Radiation Therapy	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Leukemia/Lymphoma	<input type="checkbox"/> Past	<input type="checkbox"/> Present	Blood Transfusion	<input type="checkbox"/> Past	<input type="checkbox"/> Present

Please List Other Medical Conditions or Hospitalizations

Family History:

Ulcerative Colitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Prostate Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Crohn’s Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Uterine Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Polyposis Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Ovarian Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Colon or Rectal Polyps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Colon or Rectal Cancer No Yes
Anal Cancer No Yes
Breast Cancer No Yes

Gastric Cancer No Yes
Aneurysm No Yes

Past Surgical History:

Prior Colonoscopy No Yes When _____ Where _____
Findings _____

Colon Surgery No Yes When _____ What type _____
Complications _____

Rectal Surgery No Yes When _____ What type _____
Complications _____

Anal Surgery No Yes When _____ What type _____
Complications _____

Small Bowel Surgery Lap Open Any problems _____

Bowel Obstruction Surgery Lap Open Any problems _____

Appendectomy Lap Open Any problems _____

Gall Bladder Surgery Lap Open Any problems _____

Stomach Surgery Lap Open Any problems _____

Hysterectomy Lap Open Vaginal Any problems _____

Other Abdominal Surgery What type, any problems _____

Cesarean Section No Yes how many _____

Hernia Surgery No Yes

Pelvic Floor Surgery No Yes What type, any problems _____

Heart Surgery No Yes

Pacemaker/Defibrillator No Yes

Lung Surgery No Yes

Organ Transplant No Yes What type, any problems _____

Please list all other surgeries and any complications:

List All Medications and Dosages:

List All Supplements and Herbal Agents:

Are You Allergic to Any Medicines No Yes

Please List Allergies and Reactions:

Social History:

Education _____

Occupation _____

Tobacco Use Past Now Never packs/days _____ years _____

Alcohol Use Past Now Never drinks/day _____ years _____

Recreational Drugs Past Now Never what _____ years _____

Anal Intercourse Past Now Never

Enema Use Past Now Never what type _____ frequency _____

REVIEW OF SYSTEMS: Please mark all that apply

Good health	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Kidney stone	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Declining health	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Testicular pain	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Exotic travel	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Impotence	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Municipal water	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Painful intercourse	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Well water	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Irregular periods	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Fever	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Postmenopausal	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Fatigue	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Possibly pregnant	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Weight loss	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Last menstrual period	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Glasses/contacts	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Difficulty walking	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Glaucoma	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Chronic back pain	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Cataracts	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Muscular pain/weakness	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Blurry/Double vision	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Arthritis	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Hearing Aids	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Psoriasis	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Hearing loss/Ringing	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Chronic rash	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Mouth sores	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Varicose veins	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Bleeding gums	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Stroke	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Nosebleeds	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Seizure	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Swollen neck glands	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Tremors	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Chest pain	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Chronic headaches	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Shortness of breath	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Head Injury	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Palpitations	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Memory loss/confusion	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Ankle swelling	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Anxiety	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Leg pain after walking	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Depression	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Chronic cough	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Insomnia	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Coughing blood	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Diabetes	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Asthma/Wheezing	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Thyroid disease	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Burning with urination	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Cushing's disease	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Hepatitis/Jaundice	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Anemia	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Gallstones	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Easy bruising	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Pancreatitis	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Prior blood transfusions	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Urinary leakage	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	HIV/AIDS	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Difficulty with urination	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Food allergy	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Air in the urine	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never	Latex allergy	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never
Debris in the urine	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Never				

Please Describe Anything Else Which You Feel Is Important To Your Current Condition/Health:

Patient Signature _____ Date _____