CENTER FOR COLON & RECTAL HEALTH, INC. +

BRING OR HAVE FAXED ALL RECORDS, X-RAYS, CT-SCANS AND LABWORK FROM OTHER PHYSICIANS PERTAINING TO YOUR VISIT WITH US. IF INSTRUCTED, USE A SALINE FLEET ENEMA 1 TO 2 HOURS PRIOR TO YOUR APPOINTMENT. BRING INSURANCE CARDS AND PHOTO ID.

Health History Questionnaire

NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

SURGICAL HISTORY (Including Colonoscopy)

Procedure	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (Including Vitamins, Herbals and Supplements)

Medication	Reason Taken
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

VACCINATIONS (Including Flu and Pneumonia)

Vaccine Type	Date
_____	_____
_____	_____
_____	_____

ALLERGIES/ADVERSE REACTIONS

Check Here if No Known Drug Allergies _____

Drug/Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

SEXUALLY TRANSMITTED DISEASES Y / N If Yes, Please Explain

_____

_____