Name _____ **Date of Birth** _____

Personal Health History

Check if you have had any of the following

☐ Valvular Heart Disease	☐ Pulmonary Embolism
☐ Chronic Obstructive Pulmonary Disease	☐ Coagulation Defects
☐ Pulmonary Hypertension	☐ Thrombocytopenia
☐ Venous Thrombosis Deep Vessels of Lower Extremity	☐ Obesity Morbid

Previous Cancer

Type of Cancer	Year
☐ Adrenal Neoplasm	
☐ Anal Neoplasm	
☐ Bladder Cancer	
☐ Brain Cancer	
☐ Breast Cancer	
☐ Cervical Cancer	
☐ Colon Cancer	
☐ Large Intestine Neoplasm	
☐ Liver Cancer	
☐ Lung Cancer	
☐ Skin Neoplasm Malignant Melanoma	
☐ Ovarian Cancer	
☐ Pancreatic Neoplasm	
☐ Prostate Cancer	
☐ Rectal Cancer	
☐ Scrotal Neoplasm	
☐ Gastric Cancer (Stomach)	
☐ Other:	

Previous Surgical Procedures

Procedure	Year
☐ Perineal Gynecological Surgery	
☐ Abdominoplasty	
☐ Cesarean Delivery	
☐ Colon Surgery Ascending Colon Resection	
☐ Colon Surgery Transverse Colon Resection	
☐ Colon Surgery Descending Colon Resection	
☐ Exploratory Laparoscopy	
☐ Colostomy	
☐ Ileostomy	
☐ Feeding Tube	
☐ Gastric Bypass, Banded	
☐ Bypass Stomach	
☐ Proctocolectomy - Hartman's Procedure	
☐ Oophorectomy	
☐ Genito - Urinary Tract Surgery Prostatectomy	
☐ Proctectomy	
☐ Small Intestine Resection	
☐ Intestinal Stricturoplasty	

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Change in Bowel Habit	☐ Flatus
☐ Urinary Loss of Control	☐ Bloating
☐ Unable to Restrain Bowel Movement	☐ Rectal Pain
☐ Watery Stools	☐ Perirectal Region Tissue Injury
☐ Unable to Restrain Bowel Movement Formed Stools	☐ Other:

Family History				
Please check all that apply				
	Father	Mother	Brother	Sister
Adrenal Neoplasm				
Anal Neoplasm				
Bladder Cancer				
Brain Cancer				
Breast Cancer				
Cervical Cancer				
Colon Cancer				
Liver Cancer				
Lung Cancer				
Skin Neoplasm Malignant Melonoma				
Ovarian Cancer				
Pancreatic Neoplasm				
Prostate Cancer				
Rectal Cancer				
Scrotal Neopplasm				
Gastric Cancer (Stomach)				
Thyroid Cancer				
Large Intestine Neoplasm				
Uterine Cancer				

OB/GYN Medical History
Females - Please complete if applicable (Check if you have had any of the following)
☐ Episiotomy
☐ Obstetrical Trauma Genital Tear Resulting from Childbirth
☐ Previous assisted Delivery using Forceps
☐ Prolonged Labor

Patient/Guardian Signature: _____ Date: _____