UCLA Health System

UCLA Colorectal Cancer Program

Initial Visit Health History Form

All information contained in this questionnaire is strictly confidential
and will become part of your medical record.

Name:	**DOB:**	**AGE:**

YOUR DOCTOR'S CONTACT INFORMATION	
Referring MD:	**Primary MD:**
Street Address: City/State/Zip:	Street Address: City/State/Zip:
Phone:	Phone:
Fax:	Fax:

Medical History

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, please indicate Year _____ Findings________________________________

How many bowel movements do you have per day? ___ Formed ___Semi-Formed ___Loose

Problems with fecal incontinence or soiling/leakage? ___Solid ___Liquid ___Gas

FOR WOMEN: Last PAP smear? Last mammogram?

Vaginal deliveries? ☐YES ☐NO Episiotomies/tears? ☐YES ☐NO Infant weight?

Chemotherapy History

Previous Chemotherapy: ☐YES ☐NO

Indication:

Radiation History

Previous Radiation: ☐YES ☐NO

Site:

Ver1

Please list your Medical Conditions.
(Attach additional sheet if necessary)

		Please List Other Conditions:
☐ heart disease	☐ depression	
☐ coronary artery disease	☐ anxiety	
☐ high blood pressure	☐ psychiatric illness	
☐ high cholesterol	☐ Bleeding disorder	
☐ diabetes	☐ anemia	
☐ asthma	☐ peptic ulcer disease	
☐ emphysema	☐ reflux (GERD)	
☐ sleep apnea	☐ hypo / hyperthyroid	
☐ stroke	☐ hepatitis	
☐ epilepsy	☐ liver disease / cirrhosis	
☐ arthritis	☐ cancer ________________	
☐ HIV / AIDS		

Surgical History
PLEASE LIST ALL SURGERIES YOU HAVE HAD

OPERATION / YEAR	OPERATION / YEAR	OPERATION / YEAR

Medications
(ATTACH ADDITIONAL SHEET IF NECESSARY)

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

Do you have ALLERGIES to medications? ☐ YES ☐ NO

If yes, please list the medication and your reaction

MEDICATION	REACTION

NAME:

Ver1

Social History

OCCUPATION:		MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ PARTNERED ☐ WIDOWED			
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind? Drinks per week?				
Tobacco	Do you CURRENTLY use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – pks/day	☐ Cigars - #/day			
	Did you use tobacco in the PAST? ☐ # years ☐ Year quit				
Drugs	Do you use recreational or street drugs?	☐	Yes	☐	No

Family Health History

DO ANY OF THESE CONDITIONS RUN IN YOUR FAMILY?

Ulcerative Colitis? ☐ **YES** ☐ **NO**	**Crohn's Disease?** ☐ **YES** ☐ **NO**
Colon Polyps? ☐ **YES** ☐ **NO**	

PLEASE LIST ANY OTHER MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY

Is there a Family or Personal History of Colorectal Cancer?

A **First-degree relative** (mother, father, brother, sister, or child) with any of the following conditions diagnosed before age 50?

Colon or rectal cancer	☐ **YES**	☐ **NO**
Cancer of the uterus, ovary, stomach, small intestine, urinary tract (kidney, ureter, bladder), bile ducts, pancreas, or brain	☐ **YES**	☐ **NO**

If yes, please indicate relationship________________and age at diagnosis___________

Have **you** had any of the following conditions diagnosed before age 50?

Colon or rectal cancer	☐ **YES**	☐ **NO**
Colon or rectal polyps	☐ **YES**	☐ **NO**

Do you have three or more relatives with a history of colon or rectal cancer? (this includes parents, brothers, sisters, children, grandparents, aunts, uncles, and cousins)	☐ **YES**	☐ **NO**

NAME:

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

1. Gastrointestinal

Yes No
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Dark tarry stools
☐ ☐ Abdominal pain
☐ ☐ Change in bowel habits
☐ ☐ Nausea/vomiting

2. Cardiovascular

Yes No
☐ ☐ Chest pain
☐ ☐ Shortness of breath with exertion
☐ ☐ Difficulty breathing while lying down
☐ ☐ Poor exercise tolerance
☐ ☐ Palpitations

3. Respiratory

Yes No
☐ ☐ Cough
☐ ☐ Productive cough
☐ ☐ Coughing up blood
☐ ☐ Shortness of breath
☐ ☐ Wheezing

4. Genitourinary

Yes No
☐ ☐ Urinary frequency
☐ ☐ Urinary leakage
☐ ☐ Blood in urine
☐ ☐ Painful urination
☐ ☐ Urinary discharge

5. Constitutional Symptoms

Yes No
☐ ☐ Unintentional weight loss
☐ ☐ Loss of apetite
☐ ☐ Fevers/Chills/Sweats

6. Neurologic

☐ ☐ Seizures
☐ ☐ Falling down
☐ ☐ Headaches
☐ ☐ Dizziness
☐ ☐ Numbness
☐ ☐ Memory loss
☐ ☐ Poor balance

7. Ear/Nose/Throat

Yes No
☐ ☐ Ringing in ears
☐ ☐ Hoarseness
☐ ☐ Nosebleeds
☐ ☐ Sore throat

8. Musculoskeletal

Yes No
☐ ☐ Joint pain
☐ ☐ Back pain
☐ ☐ Muscle aches
☐ ☐ Muscle weakness

9. Endocrine

Yes No
☐ ☐ Heat or Cold Intolerance
☐ ☐ Excessive thirst
☐ ☐ Excessive urination

10. Skin

Yes No
☐ ☐ Suspicious growths/sores/moles
☐ ☐ Itching
☐ ☐ Rash/eruptions

11. Breast/Gyn

Yes No
☐ ☐ Breast lump
☐ ☐ Nipple discharge
☐ ☐ Heavy menstrual periods
☐ ☐ Painful menstruation
☐ ☐ Stool or air vaginally

12. Psychiatric

Yes No
☐ ☐ Thoughts of suicide
☐ ☐ Anxiety
☐ ☐ Panic attacks

13. Allergy/Immunology

Yes No
☐ ☐ Hayfever
☐ ☐ Hives

14. Eyes

Yes No
☐ ☐ Loss of vision
☐ ☐ Blurring
☐ ☐ Discharge
☐ ☐ Tearing

NAME:

Physician Signature: ______________________ Date: _______ ver1