SUSAN C BRILEY, M.D.
Patient History Form

NAME: _____ DATE: _____ AGE: _____

Referring Physician: _____ Primary Care Physician: _____

What is your reason for today's visit? _____

1. When did this problem start? _____ 2. Where is this problem located? _____

3. What makes this problem worse? _____

4. **Current Symptoms (*Please check any you are experiencing*)**

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Weight Loss
- ☐ Vomiting
- ☐ Change in Bowel Habits
- ☐ Itching
- ☐ Leakage
- ☐ Protrusion

Other Symptom: _____

Previous Surgery (of any kind) _____
_____

Previous Hospitalizations: _____
_____

Radiation Treatment: _____

Medical Conditions: (***Please check all that apply***)

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Asthma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Cancer type: _____

Other Conditions: _____

Medicines and Doses (including aspirin/laxatives):_____
_____

Allergies, If Any (please describe reactions) _____

Family History: (***Please check if you have a father, mother, sister or brother with***):

- ☐ Colon Rectal Cancer
- ☐ Breast Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Ovarian/Uterine Cancer
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Stroke
- ☐ Bleeding Problems
- ☐ Other: _____

Social History: Occupation: _____

Tobacco Yes☐ No ☐ Alcohol Yes☐ No ☐

Patient Signature _____ Physician Signature _____