Date:______________________

ROBERT M. WEST, D.O.

CHIEF COMPLAINT: ____

HISTORY OF THE PRESENT ILLNESS:

Describe the **signs/symptom**s that you have: ____

When did the signs start?: ____

Are you experiencing pain? □ Yes □ No If yes, how would you rate your pain on a scale of 1 to 10, 10 being the worst?

Please circle: **1 2 3 4 5 6 7 8 9 10**

Describe your pain: □ Comes and goes □ Constant □ Other (Describe)______________________________

Please put an "X" in the box that applies what you are experiencing:

Daily bowel movements	**Rectal bleeding**	**General**
□ More than one movement per day	□ Bright red	□ Nausea / Vomiting
□ Hard bowel movements	□ Dark red	□ Diarrhea
□ Loose bowel movements	□ On toilet paper	□ Constipation
□ Pain with bowel movements	□ Dripping in bowl	□ Impacted
□ Abdominal pain	□ Outside of stool	□ Acid Reflux / Heartburn
□ Protusion of rectal tissue:	□ Mixed in stool	□ Rectal itching
□ constantly □ with bowel movement	□ Rectal drainage	□ Loss of appetite

MEDICAL HISTORY:

Are you HIV positive? Yes □ No □ Don't know □

Have you had:	Date:	Results:		Date:	Results:
□ Barium Enema			□ Colonoscopy		
□ Lower GI Study			□ Sigmoidoscopy		

Family History: Colon Cancer: Yes □ No □ Polyps: Yes □ No □

Do you have any allergies to: □ Food □ Medication(s) □ Latex □ Iodine □ No allergies

Please list **allergies** to medication and reactions:

/	/
/	/

MEDICATIONS:

List all current medications, including prescription, supplements and over the counter drugs:

____

____

____

____

______________________________ ______________

Patient Signature Date

______________________________ ______________

Legal guardian if other than patient Date