GRSA

Name:_____DOB: _____ Age: _____ Gender: (M) (F) Today's Date:_____

Referring Physician or Primary Care Physician: _____ Account Number:_____

CHIEF COMPLAINT
(Why are you here today?)_____

A. SOCIAL HISTORY:

Habits: Tobacco ☐ Yes (Cigarettes, Cigars, Pipe Etc.) Frequency of use _____ ☐ No

B. VACCINATION HISTORY: Influenza (Flu) Vaccine ☐ Yes Date: _____ ☐ No ☐ Allergy to vaccine

Pneumonia Vaccine Patients 50 years of age and older: ☐ Yes ☐ No

C. REVIEW OF SYSTEMS/SYMPTOMS: *New Patients please check all that apply. Returning patients: Changes since last visit:* ☐ Yes ☐ No

Date of last visit: _____. If yes or one year since last visit, complete all that applies below, if no skip to section D.

Gastrointestinal: ☐ Constipation ☐ Diarrhea ☐ Incontinence (loss of bowel control) ☐ Abdominal Pain ☐ Bloating ☐ Nausea/Vomiting
☐ Rectal bleeding ☐ Swelling around the anus ☐ Prolapse (tissue coming out of the anus) ☐ Anal pain ☐ Itching ☐ Burning

Respiratory: ☐ Frequent Coughing ☐ Shortness of Breath

Cardiac: ☐ Chest pains ☐ Swollen Feet, Ankles, or Hands ☐ Sudden/Irregular heart beat changes

Neurological: ☐ Burning/Numbness/Tingling ☐ Tremors (where): _____ ☐ Dizziness

Musculoskeletal: ☐ Neck/Back pain ☐ Limb Pain (where):_____
☐ Joint Swelling/Stiffness ☐ Muscle or Joint Weakness ☐ Recent Falls ☐ Limitation of Activity ☐ Unsteady Gait

EENT: ☐ Eye Disease or injury ☐ Sinus Problems ☐ Mouth sores ☐ Nose bleeds ☐ Sore Throat ☐ Glasses ☐ Hearing Aid
☐ Blind/Visual Impairment ☐ Hearing Loss

Constitutional Symptoms: ☐ Fever ☐ Headaches

Genitourinary: ☐ Burning/Painful Urination ☐ Blood in Urine

Skin/Hematologic/Lymphatic: ☐ Anemia ☐ Easy Bruise or Bleed ☐ Rashes

D. PAST MEDICAL HISTORY: *New Patients please check all that apply. Returning patients: Changes since last visit:* ☐ Yes ☐ No

If yes or one year since last visit complete all that applies below, if no skip to section E.

Gastrointestinal: ☐ Colon polyps' ☐ Irritable bowel syndrome ☐ Crohn's disease ☐ Ulcerative colitis ☐ Hiatal Hernia ☐ Liver Disease
☐ Other:_____

Respiratory: ☐ Asthma ☐ Bronchitis ☐ COPD/Emphysema ☐ Sleep Apnea/CPAP ☐ Other: _____

Cardiac: ☐ Heart Attack ☐ Heart Failure ☐ High Blood Pressure ☐ High Cholesterol ☐ Other:_____

Neurological: ☐ Stroke/TIA ☐ Spinal Cord Injury ☐ Seizures ☐ Other: _____

Musculoskeletal: ☐ Arthritis ☐ Lupus ☐ Fibromyalgia ☐ Osteoporosis ☐ Other:_____

Cancer: _____ ☐ Chemotherapy ☐ Radiation Therapy ☐ Other: _____

Endocrine: ☐ Diabetes ☐ Thyroid Problems ☐ Gout ☐ Other:_____

Infectious Disease: ☐ TB ☐ Herpes ☐ HIV/AIDS ☐ Hepatitis ☐ Other: _____

Genitourinary: ☐ Kidney Stones ☐ Other: _____

E. PREVIOUS SURGICAL HISTORY: *New Patients please complete all that apply. Returning patients: Changes since last visit:* ☐ Yes ☐ No

If yes or one year since last visit, complete all that applies below with dates.

Colonoscopy: Date: _____Physician: _____
Colon surgery: Date: _____Physician: _____
Anal or rectal surgery: Date: _____Physician: _____
Artificial joints: Date: _____Physician: _____
Heart valves: Date_____Physician: _____
Hysterectomy: Date: _____Physician: _____
Obstetric: _____ # of pregnancies _____ # vaginal deliveries _____ # of C-sections
Other (within last 5 yrs): _____

NEW PATIENT

F. FAMILY HISTORY: *New Patients please complete all that apply. Returning patients: Changes since last visit:* ☐ Yes ☐ No

Relationship to you: Age at diagnosis:

☐ Breast cancer _____

☐ Ovarian cancer _____

☐ Uterine cancer_____

☐ Thyroid cancer _____

☐ Colon/Rectal cancer _____

☐ Ulcerative colitis _____

☐ Crohn's disease_____

☐ Polyps _____

☐ FAP_____

☐ Other: _____

Medical Conditions: ☐ Diabetes ☐ High Cholesterol ☐ Heart Disease ☐ Lung Disease

PATIENT SIGNATURE: _____ **DATE:** _____

Below to be completed by Physician: _____

Vital Signs: Pulse _____ Respiration _____ BP _____/_____ Temp _____Height___ Weight____ BMI____

Patient received tobacco cessation brochure and/or counselling: ☐ Yes ☐ No

Follow up for BMI if outside normal parameters. Please check one:

☐ Documentation of education ☐ Dietary supplements ☐ Referral ☐ Pharmacological interventions ☐ Exercise counseling ☐ Nutrition counseling

Chief Complaint: _____

History of Present Illness: _____

Physical Examination:_____

- Integumentary Exam: _____No Abnormalities Noted:_____
- Lymphatic / Neck:_____No Abnormalities Noted:_____
- ENT:_____No Abnormalities Noted:_____
- Eyes: _____No Abnormalities Noted:_____
- Cardiovascular System:_____No Abnormalities Noted:_____
- Lungs_____No Abnormalities Noted:_____

❖ Rhythm_____

❖ Murmurs_____

❖ Heart Sounds _____

❖ Edema _____

❖ Bruits (Carotid / Femoral)_____

- Peripheral abdominal pulses _____
- Gastrointestinal: _____No Abnormalities Noted:_____

❖ Distention _____

❖ Ascites _____

❖ Bowel sounds _____

- Rectal Masses _____

❖ Liver_____

❖ Spleen _____

- Genitourinary:_____No Abnormalities Noted:_____
- Musculoskeletal / Extremities: _____No Abnormalities Noted:_____
- Neurological: _____No Abnormalities Noted:_____

Impressions and Plan:

_____

_____

Physician Signature:_____ Date/Time _____

Georgia Colon & Rectal Surgical Associates

NORTHSIDE HOSPITAL

Georgia Colon & Rectal Surgical Associates

PATIENT NAME _____ DATE OF BIRTH _____

Medication Allergy	Reaction

Medications (current medications to include all prescriptions, overthecounters, herbals, vitamin/mineral/dietary nutritional supplements) **to include dose, frequency and route of administration** **Daily Aspirin? Yes/ No Plavix? Yes/ No Coumadin? Yes/ No**	Med List Reviewed Reconciled in Chart MA Date/Time/ Initial	Med List Reviewed Reconciled in Chart MA Date/Time/ Initial	Med List Reviewed Reconciled in Chart MA Date/Time/ Initial	Med List Reviewed Reconciled in Chart MA Date/Time/ Initial	Med List Reviewed Reconciled in Chart MA Date/Time/ Initial

MEDICATIONS RECONCILIATION