Digestive
SURGERY CENTER

RAUL RAMOS, M.D.,F.A.C.S.
Diplomate American Board of Surgery
Diplomate American Board of Colon and Surgery

PERSONAL MEDICAL HISTORY

Name:____

Describe your symptoms (What brought you to the doctor) ____________________________

____

Are you allergic to any drugs or medicine? ____________________________________

Do you have any of the following now?
(Please circle Yes or No)

Rectal Bleeding	Yes	No	Mucous in the stool	Yes	No
Rectal Pain	Yes	No	Ribbon like stools	Yes	No
Rectal Fullness	Yes	No	Change in Bowel Habits	Yes	No
Rectal Itching	Yes	No	Constipation	Yes	No
Rectal Discharge	Yes	No	Requires Laxatives	Yes	No
Rectal Burning	Yes	No	Require Enemas	Yes	No
Rectal Protrusion	Yes	No	Diarrhea	Yes	No

Do you know of any close relative who has had:

Cancer ____________________________ Diabetes ______________________________
High Blood Pressure __________ Heart Attack __________ Bleeding Tendencies __________
Colitis _______________ Colon or Rectal Cancer _______________ Polyps _______________

Social History

Yes No Do you Smoke? _______________ For how many years? _______________
Yes No Do you drink over 6 cups of coffee per day? __________________________
Yes No Do you regularly drink alcohol? How much? __________________________

What type of work do you do? ____