BAY AREA COLON & RECTAL SURGEONS

365 Lennon Lane, Ste. 290, Walnut Creek, CA 94598

PATIENT REGISTRATION

WELCOME! Thank you for choosing our practice. In order to properly serve you, we will need the following information. All information provided are **STRICTLY CONFIDENTIAL. PLEASE PRINT.**

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Home Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Which Phone No(s). Okay to leave message: _____

Date of Birth: _____ Gender: ___Female ___ Male Social Sec. No.:_____

Marital Status: _____ Religion: _____ Email Address: _____

Employer: _____ Occupation: _____

How do you prefer to be addressed? _____ Primary Care Physician: _____

Insurance Information

Primary Insurance: _____ ID No. _____ Group No. _____

Policy Holder: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ ID No. _____ Group No. _____

Policy Holder: _____ DOB: _____ Relationship: _____

Emergency Contact

Person to notify in case of emergency: _____Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Payment for Services

I understand that it is my responsibility to verify with my insurance carrier if my physician is a Participating Provider. I realize that I am financially responsible for all medical services rendered to me and or my dependents regardless of the decision involving reimbursements by my insurance carrier. I authorize my physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my Insurance Company. I hereby assign my insurance benefits to be paid directly to Bay Area Colon & Rectal Surgeons.

Patient`s Signature or
Authorized Representative: _____

Print Name: _____ Date: _____

BAY AREA COLON RECTAL SURGEONS

WWW.BACRS.COM TEL: (925) 274-9000 FAX: (925) 274-9004

PATIENT HISTORY FORM

DATE ____/____/____ REFERRING DOCTOR _____

NAME _____ PRIMARY CARE DOCTOR _____

BIRTH PLACE: _____ ETHNICITY: _____

REASON FOR VISIT _____

PREFERRED LOCAL PHARMACY: _____
Name Street City Phone

SUPPLEMENTS		
Please list all current supplements:		
Name of supplement	Dose	Frequency

ALLERGIES	
Please list all drug allergies:	
Drug	Reaction
☐ Latex	

MEDICATIONS		
Please list all current medications, including vitamins:		
Name of medication	Dose	Frequency

SEE ATTACHED __

Reviewed by MD & discussed with patient _____

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Acute myocardial infarct (heart attack)	☐ Yes ☐ No	Coronary artery disease/heart attack	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
Chronic Kidney Disease	☐ Yes ☐ No	High blood pressure/Hypertension	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
COPD/emphysema	☐ Yes ☐ No	Internal defibrillator (AICD)	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Type _____		Sleep Apnea	☐ Yes ☐ No
Type _____		Stroke	☐ Yes ☐ No
		Taking Coumadin/Plavix/Aggrenox	☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

FAMILY HISTORY

Please answer the following questions about your family members:

Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		

Spouse

Please list any significant medical problems (if any):

	If Living		*If Deceased*	
	Age	*Health*	*Age*	*Cause*
1)				

Brother(s)/ Sister (s)

Please list any significant medical problems (if any):

	If Living		*If Deceased*	
	Age	**Health**	**Age**	**Cause**
1)				
2)				
3)				
4)				
5)				
6)				

SEE ATTACHED __

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	FAMILY HISTORY (cont'd)
Son(s)/ Daughter(s)	Please list if any significant medical problems (if any): *If Living* — Age, Health; *If Deceased* — Age, Cause 1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____
Family history of	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)
Family History of: ☐ Colon Cancer _____ ☐ Colon Polyp _____ ☐ Crohn's Disease _____ ☐ Ulcerative Colitis _____ ☐ Other Gastrointestinal Cancers: _____	
Previous Colonoscopies: Year _____ by Dr. _____ Diagnosis _____ **Previous Endoscopies:** Year _____ by Dr. _____ Diagnosis _____	

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	Amount Consumed: ☐ 1-3 ☐ 3-5 ☐ >5	
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? How many sodas?	
Employment		
	Occupation (past or present):	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

REVIEW OF SYSTEMS **Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:**	
Constitutional Fever ☐ Yes ☐ No Unexplained weight loss ☐ Yes ☐ No Other: _____	**HEENT** Frequent bleeding teeth ☐ Yes ☐ No Frequent bleeding nose ☐ Yes ☐ No Other: _____

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Neurologic/Psychiatric

Depression	☐ Yes ☐ No
Weakness	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No
Memory loss	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Spinal cord injury	☐ Yes ☐ No
Migraine headaches	☐ Yes ☐ No
Other: _____	

Metabolic/Endocrine

Excessive thirst	☐ Yes ☐ No
Too cold	☐ Yes ☐ No
Other: _____	

Immunologic

Hay fever	☐ Yes ☐ No
Food allergies	☐ Yes ☐ No
Other: _____	

Respiratory

Shortness of breath	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Other: _____	

Musculoskeletal

Joint pain	☐ Yes ☐ No
Back pain	☐ Yes ☐ No
Artificial joints	☐ Yes ☐ No
Other: _____	

Cardiovascular

Chest pain	☐ Yes ☐ No
Irregular pulse	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No
Heart valve problem	☐ Yes ☐ No
Swelling legs	☐ Yes ☐ No
Other: _____	

Vascular

Pain in limb	☐ Yes ☐ No
Varicose Veins	☐ Yes ☐ No
Other: _____	

Dermatologic

Rash	☐ Yes ☐ No
Abnormal pigmentation	☐ Yes ☐ No
Other: _____	

Hematologic

Easy bruising or bleeding	☐ Yes ☐ No
Blood clots in arms or legs	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Other: _____	

Genitourinary

Blood in urine	☐ Yes ☐ No
Urinary burning sensation	☐ Yes ☐ No
Night time urination	☐ Yes ☐ No
Other: _____	

Gastrointestinal

Poor appetite	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Trouble swallowing	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Pain with swallowing	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Regurgitation food	☐ Yes ☐ No	Pancreatic disease	☐ Yes ☐ No
Nausea	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Vomiting blood	☐ Yes ☐ No	Black colored stool	☐ Yes ☐ No
History peptic ulcer disease	☐ Yes ☐ No	Mucus in stool	☐ Yes ☐ No
Bloating	☐ Yes ☐ No	Fecal incontinence	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Anal pain or itching	☐ Yes ☐ No
Gallbladder disease	☐ Yes ☐ No		

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