Date_____________

ONLINE CONSULTATION FORM

Name :

Date of Birth : **Age** :

Home Address :

Home phone : **Cell phone** :

Work phone : **Email address :**

Occupation :

Family Doctor : **Referring Doctor :**

Address : **Address :**

Phone : **Phone :**

Main reason for Consultation :

MEDICAL HISTORY
(Have you seen a doctor for any of the following illnesses?)

High blood pressure	YES	NO
Heart disease	YES	NO
High Cholesterol	YES	NO
Diabetes	YES	NO
Kidney disease	YES	NO
Asthma or Lung disease	YES	NO
Tuberculosis	YES	NO
Liver disease or hepatitis	YES	NO
Arthritis	YES	NO
Bleeding disorder	YES	NO
HIV	YES	NO
Cancer	YES	NO

Other____

Have you ever been **admitted to a hospital** for a serious illness (such as a stroke, heart attack, pneumonia, car accident)? YES NO
Please list:

SURGICAL HISTORY

Have you ever undergone **surgery**? YES NO
If yes, please list operations and dates:

Have you ever had a **colonoscopy**? YES NO
If yes, please list dates:

FAMILY HISTORY

Have any of your relatives had cancer? YES NO
Please list them and the type of cancer:

Have any of your relatives had Inflammatory Bowel Disease? YES NO

Please list any other significant family medical history (such as heart disease, diabetes, stroke, bleeding disorder, etc)

SOCIAL HISTORY

Do you smoke now? YES NO How much?
Have you ever smoked? YES NO
If yes, for how many years? When did you quit?
Do you drink alcohol? YES NO
If yes, how much? How often?
Have you used recreational drugs? YES NO
If yes, which ones?

Marital Status: Single Married/PartnerWidowedDivorced

Do you exercise? YES NO

(For women only)
Are you pregnant or breast feeding? ______________________
Date of your last menstrual period: ______________________
How many children do you have? ______________________
How were they delivered?

Did you have any injury during delivery? YES NO

ALLERGIES
Are you **allergic** to anything (medications, foods, latex)? YES NO
If yes, please list:

MEDICATIONS:
Please list all **medications and/or supplements** you are taking now with times and dosages:

REVIEW OF SYSTEMS
(Please check any symptoms you currently have)

Constitutional
Fever/chills/night sweats Unexplained weight loss Fatigue/weakness

Head and Neck
Headaches/migraines Dizziness/lightheadedness Change in vision
Difficulty hearing/ringing in ears Sleep apnea Sinus congestion

Cardiovascular
Chest pain/discomfort Palpitations Irregular heart beat
Heart murmur Leg/feet swelling (edema) Shortness of breath

Respiratory
Cough/wheeze Blood with coughing

Blood/lymphatics
Easy bleeding/bruising Anemia Received a blood transfusion at any time

Skin
New skin lesion Rash

Breast
Breast lump Nipple discharge

Endocrine
Cold/heat intolerance Excessive thirst

Psychiatric
Sleep problems Depression Anxiety/stress

Neurological

Numbness/tingling | Memory loss | Seizures

Musculoskeletal

Muscle/joint pain | Back pain/injury | Muscle weakness

Genitourinary

Leaking urine | Nighttime urination | Painful/bloody urination

Difficulty/concern with sexual function | Genital sores

Gastrointestinal

Abdominal/stomach pain | Nausea/vomiting

Heartburn/reflux | Difficulty swallowing

Bloating | Decreased appetite

Constipation | Straining to move your bowels

Diarrhea | Change in bowel movement/habits

Blood from the rectum | Anal/rectal pain

Anal itchiness | Anal swelling/lump/bumps

Stool incontinence | Stool seepage/staining