

**NEW PATIENT HISTORY FORM**  
**DUKE COLON and RECTAL SURGERY**

Please check your physician and your clinic site.

**PHYSICIANS**

Dr. Christopher Mantyh

Dr. Linda M. Farkas

Dr. John Migaly

Dr. M Benjamin Hopkins

Dr. Julie K. Marosky Thacker

**CLINIC SITES**

Duke Clinic 2B 200 Trent Drive  
Durham NC 27710

Duke -Raleigh 3404 Wake Forest Road  
Raleigh NC 27609

**Date of appointment** \_\_\_\_\_ **Your name** \_\_\_\_\_ **age** \_\_\_\_\_

**Birthdate** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Your email address** \_\_\_\_\_

**Marital status**  Single  Married  Divorced  Separated  Widowed  Partnered

**Chief Complaint** \_\_\_\_\_

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**Have you had previous anal or rectal surgery?**  YES  NO

**Please list all surgeries (and complications) AND admissions to the hospital which did not require surgery** \_\_\_\_\_

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**Please List all medical problems (such as diabetes, hypertension etc)**

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**Do you take laxatives/ fiber supplements or anti-diarrhea medications?**  Yes  No

**If yes, please list name of products and how often** \_\_\_\_\_

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**Medications (prescription and non-prescription) List name, dose and frequency. (i.e. Atenolol 20 mg 1x/day)** \_\_\_\_\_

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**Allergies (medical, food, etc and the reaction you had):**

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**FAMILY HISTORY** a= ALIVE; d- DECEASED---In the boxes below please list any significant medical problems (especially **colon, uterine, ovarian, brain, kidney, or bladder cancers**; colitis, inflammatory bowel disease or colon polyps)

**Has anyone in your family have had more than one cancer?**  Yes  No  
**Has anyone in your family had cancer before the age of 50 years of age?**  Yes  No

<b>Maternal grandmother</b> <input type="checkbox"/> A / <input type="checkbox"/> D	<b>Paternal grandmother</b> <input type="checkbox"/> A / <input type="checkbox"/> D
<b>Maternal grandfather</b> <input type="checkbox"/> A / <input type="checkbox"/> D	<b>Paternal grandfather</b> <input type="checkbox"/> A / <input type="checkbox"/> D
<b>Mother</b> <input type="checkbox"/> A / <input type="checkbox"/> D	<b>Father</b> <input type="checkbox"/> A / <input type="checkbox"/> D
<b>Maternal Aunts and Uncles</b> <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D	<b>Paternal Aunts and Uncles</b> <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D
<b>Sisters and Brothers</b> <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D	<b>Children</b> <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D <input type="checkbox"/> A / <input type="checkbox"/> D
<b>Use this space for any other relatives with important medical problems:</b>	

**WOMEN ONLY:**

Last pap smear \_\_\_\_\_ # Pregnancies \_\_\_\_\_ # Live Births \_\_\_\_\_ #episiotomies \_\_\_\_\_  
 Last mammogram \_\_\_\_\_ Ages of children \_\_\_\_\_ Largest baby's weight \_\_\_\_\_

<p><b>Have you ever had your colon examined?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know                  If yes, please state the date each exam was performed:  <b>Barium enema</b> _____  <b>Proctoscopy</b> _____  <b>Flexible sigmoidoscopy</b> _____  <b>Colonoscopy</b> _____  <b>I don't know the name</b> _____</p>
<p><b>Do you smoke?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Did you ever?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Do you drink alcohol?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Did you ever?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

	Name	Address and phone number
<b>Referring Physician/Physician requesting consult</b>		
<b>Primary Care Doctor</b>		
<b>Please list all doctors you would like to receive record updates of your records (referring/ consulting doctors will always receive an update)</b>		

**Please check if you had one of the following Y=Yes N=No**

<input type="checkbox"/> Y <input type="checkbox"/> N Blood per rectum	<input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat	<input type="checkbox"/> Y <input type="checkbox"/> N Gallstones	<input type="checkbox"/> Y <input type="checkbox"/> N Hypothyroidism
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Chest pain/pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Hyperthyroidism
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty controlling stool	<input type="checkbox"/> Y <input type="checkbox"/> N Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty controlling urine	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis
<input type="checkbox"/> Y <input type="checkbox"/> N Fainting spells	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever	<input type="checkbox"/> Y <input type="checkbox"/> N Double vision	<input type="checkbox"/> Y <input type="checkbox"/> N Chronic cough
<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Contact lenses/glasses	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma
<input type="checkbox"/> Y <input type="checkbox"/> N Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N Enlarged heart	<input type="checkbox"/> Y <input type="checkbox"/> N Loss of vision	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema
<input type="checkbox"/> Y <input type="checkbox"/> N Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N Wheezing
Depression or anxiety requiring <input type="checkbox"/> Y <input type="checkbox"/> N counseling <input type="checkbox"/> Y <input type="checkbox"/> N medication	<input type="checkbox"/> Y <input type="checkbox"/> N Wake up in the middle of night short of breath	<input type="checkbox"/> Y <input type="checkbox"/> N Dangle feet over the side of bed at night because of foot pain	<input type="checkbox"/> Y <input type="checkbox"/> N Treated with steroids
<input type="checkbox"/> Y <input type="checkbox"/> N Treated with blood thinners	<b>Can you walk up two flights of stairs?</b> <input type="checkbox"/> Y <input type="checkbox"/> N If not, why not? <input type="checkbox"/> Out of breath <input type="checkbox"/> Legs hurt <input type="checkbox"/> Legs tired <input type="checkbox"/> Other (please explain)		
<input type="checkbox"/> Y <input type="checkbox"/> N Have you or any family members have ever had problems with high fevers with anesthesia?	<b>What is your sickle cell status?</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Trait <input type="checkbox"/> Unknown		

**Please check if in the PAST 6 MONTHS you have been troubled with:**

<input type="checkbox"/> Y <input type="checkbox"/> N change in bowel habits (either consistency or frequency)	<input type="checkbox"/> Y <input type="checkbox"/> N Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Backache
	<input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N Reflux	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N Weight loss	<input type="checkbox"/> Y <input type="checkbox"/> N Slow urine stream	<input type="checkbox"/> Y <input type="checkbox"/> N Bloody sputum	<input type="checkbox"/> Y <input type="checkbox"/> N Nipple discharge
<input type="checkbox"/> Y <input type="checkbox"/> N Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> N Breast mass
<input type="checkbox"/> Y <input type="checkbox"/> N Feces mixed with urine during urination	<input type="checkbox"/> Y <input type="checkbox"/> N Indigestion	<input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N Air mixed with urine
	<input type="checkbox"/> Y <input type="checkbox"/> N Vomiting		<input type="checkbox"/> Y <input type="checkbox"/> N Pus in urine

**Use this space for any other medical history that you feel is important:**

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**How were you aware of Duke Colon and Rectal Surgery**

<input type="checkbox"/> Yellow Book	
<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Web-site	Which web site?
<input type="checkbox"/> Hospital referral	Name of hospital
<input type="checkbox"/> Another doctor	Name of doctor if different than referral doctor
Other	Please explain

**Please mail or fax this to your doctor's office for more efficient care on the day of your clinic appointment. If you fax or mail this PLEASE KEEP ONE COPY FOR YOURSELF AND BRING ON YOUR CLINIC DAY UNLESS YOU HAVE CONFIRMATION FROM US THAT WE RECEIVED YOUR FORM.**

**If you are able to make an attachment and would like to email it to your doctor's office. Call the office for the email address it should be sent to.**

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