Claudine E. Siegert M.D. – Gentry Caton M.D.

GENERAL SURGERY – COLORECTAL SURGERY
A DIVISION OF RADIATION THERAPY ASSOCIATES OF WNC, PA
1 Hospital Dr. Suite 102 Asheville, NC 28801

PATIENT'S Full Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

Gender: M F Date of Birth ___/___/___ Age _____ Height: ____ ft. ___ in.

Social Security No: _____ Language: English _____ Other _____

Ethnicity: Hispanic/Latino _____ Non-Hispanic: _____ Race: _____

Marital status (circle one): Single Married Widowed Divorced Separated Partnered

Home phone _____ Cell phone _____ Work phone _____

Your Employer _____ Employers phone: _____

Employment Status: Full _____ Part-time_____ Unemployed _____ Retired_____ Student _____

Emergency contact Name _____ Relationship _____ Contact phone _____

Referred by _____ Family Physician _____

Other physicians involved in your care: _____

FOR SPOUSE OR PARENT OF PATIENT

SPOUSE / PARENT'S Full Name _____

Address (if different than patient's :) _____

Date of Birth: ___/___/___ Social Security No. _____

Home phone _____ Work phone _____

Employer _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Policy Holder _____ Policy Holder _____

Effective Date _____ Effective Date _____

Is this a work-related injury? Y_____ N _____ Date of Injury: _____

(PLEASE COMPLETE ALL THREE PAGES)

Patient's Name _____ **DOB** ___/___/___ **Date** _____

ARE YOU ON HOME OXYGEN? Yes___ No ___ CPAP OR BREATHING DEVICE AT HOME? Y___ N___

****ALLERGIES**** ☐ **NONE**

List all medications / drugs to which you are allergic & your reaction to the medication: _____

_____

SOCIAL HISTORY (circle each answer)

Do you smoke? Y N How much do you smoke per day? _____

Have you been a smoker in the past? Y N When did you quit? _____

Do you drink alcohol? Y N How much and how often? _____

Do you use illicit drugs? Y N What type? _____

Do you have any children? Y N How many? _____

FAMILY HISTORY

What illnesses have been in your family? (Explain each)

___Cancer _____

___Diabetes _____

___Heart disease _____

___Lung disease _____

___Crohn's/Ulcerative Colitis _____

___Other _____

REVIEW OF SYSTEMS (Check those symptoms which you currently have.)

Constitutional
___Feeling Fine
___Weight Loss
___Weight Gain
___Frequent Fevers
___Fatigue/Tired

Eyes
___Sensitivity to Light
___Vision Changes
___Wear Glasses/Contacts

Ears/Nose/Throat
___Hearing loss
___Lump in neck
___Difficulty Swallowing

Cardiovascular
___Low Exercise Tolerance
___Chest Pain
___Palpitations
___Edema/Swelling

Respiratory
___Shortness of Breath
___Cough
___Cough Blood
___Wheezing

Gastrointestinal
___Loss of Appetite
___Nausea
___Vomiting
___Heartburn/Reflux
___Constipation
___Diarrhea
___Abdominal Pain
___Bloody Bowel Movement
___Painful Bowel Movement

Genito-urinary
___Frequent Urination
___Painful Urination
___Blood in Urine
___Incontinence
___Vaginal Discharge

Musculoskeletal
___Joint Pain
___Joint Swelling
___Joint Stiffness
___Muscle Pain
___Back Pain

Skin/Breast
___Rashes
___Itching
___Non-healing lesion
___Breast pain or Lumps

Hematology
___Easy bruising
___Swollen glands
___Slow to heal
___Past transfusion

Endocrine
___Night Sweats
___Excessive Thirst
___Temperature intolerance

Neurological
___Headache
___Dizziness
___Seizure
___Tremors

Psychological
___Insomnia
___Depression
___Anxiety

Allergic/Immunologic
___Frequent infection
___Chemotherapy
___Radiation

Patient's Name _____ DOB ___/___/___ Date _____

Reason for this visit _____

PAST MEDICAL HISTORY ☐ **NONE**

Circle which of the following conditions for which you have been treated, or are currently being treated:

Hepatitis B/C	**Blood Thinner**	**Arthritis**	**Colon Polyps**
Heart Failure	**Renal Insufficiency/Failure**	**Osteoporosis**	**Cancer**
Heart-Abnl rhythm	**Kidney Stones**	**Thyroid Problem**	**- Lung**
Heart Clogged Arteries	**Prostate Enlargement**	**Goiter**	**-Breast**
Heart Attack/MI	**Reflux/Heartburn**	**Glaucoma**	**-Colon**
High Blood Pressure	**Hiatal Hernia**	**Cataracts**	**-Liver**
High Cholesterol	**Hernia of Abdominal Wall**	**Depression**	**-Skin**
Stroke/TIA	**Pancreatitis**	**Anxiety**	**-Esophageal**
Obesity	**Stomach Ulcers**	**Psychiatric Disorders**	**-Uterine**
Diabetes	**Diverticulitis**	**Seizures**	**-Prostate**
Anemia	**Ulcerative Colitis**	**Fibromyalgia**	**-Testicular**
Emphysema	**Crohn's Disease**	**Multiple Sclerosis**	**-Leukemia/Leukemia**
Asthma	**Accidental Bowel Movements**	**HIV/AIDS**	**-Other_____**
COPD	**Last Colonoscopy Date_____**	**Last Mammography Date_____**	
Sleep Apnea			

OTHER conditions being treated by a physician_____

_____

Have you ever received chemotherapy? Y___ N___ When? _____

Have you ever received radiation therapy? Y___ N___ When? _____

FEMALES: Date of last menstrual cycle: ___/___/___ Could you possibly be pregnant? Y___ N___

PAST SURGICAL HISTORY ☐ **NONE**

What operations have you had? (Give approximate year)

_____ _____

_____ _____

_____ _____

Have you ever had a bad reaction to anesthesia? Y___ N___ Explain _____

Have you ever had a bleeding problem during, or after surgery? Y___ N___ Explain _____

CURRENT MEDICATION ☐ **NONE** ☐ ☐

COUMADIN /WARFARIN/PLAVIX or Other Blood Thinner_____? YES NO Dosage_____

Pharmacy Name: _____ Ph#_____

List all current medications including **INHALERS and HERBAL SUPPLEMENTS** and dosages:

_____ _____

_____ _____

_____ _____

(PLEASE COMPLETE ALL THREE PAGES) Reviewed by Physician (initial) _____