

**R.V. RAJ, M.D., M.S. (Surg) F.A.C.S., F.I.C.S.**

Diplomate American Board of Surgery  
General Surgery and Vascular Surgery

**PATIENT REGISTRATION** DATE

NAME	MARITAL STATUS <b>S   M   W   D   SEP</b>	DATE OF BIRTH	
STREET ADDRESS		CITY	
PHONE (HOME)	(WORK)	STATE, ZIP	
<b>SPOUSE'S NAME</b>	DATE OF BIRTH	OCCUPATION/EMPLOYER	PHONE
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION
S S #	DRIVER'S LICENCE #	REFERRED BY	

**INSURANCE & BILLING INFORMATION**

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE #

**PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE	
SUBSCRIBER'S NAME	I.D #	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE	
SUBSCRIBER'S NAME	I D #	GROUP #	BENEFIT CODE
MEDICARE #	MEDICAID I D #		
OTHER COVERAGE			

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. RAJ, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. RAJ, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**MEDICARE • MEDICAID**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf

*A photocopy of these assignments shall be valid as the original.*

PATIENT (please print)	DATE
PARENT / GUARDIAN (please print)	SIGNATURE

FORM 1001 12/84 120 WOLFELOW FIRM DR. COMPTON

# INFORMATIC FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination

TODAY'S DATE

It will help your physician to know not only about your health but also about your family and relatives

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ RACE OR NATIONALITY OF PARENTS \_\_\_\_\_

RELIGION \_\_\_\_\_ EDUCATION (highest level attained) \_\_\_\_\_ OCCUPATION \_\_\_\_\_ HOW LONG \_\_\_\_\_

PRESENT MARRIAGE (Year married) \_\_\_\_\_ PREVIOUS MARRIAGE (Year married and duration) \_\_\_\_\_

WHERE AND WHEN HAVE YOU LIVED OR TRAVELLED OUTSIDE THE U.S. AND CANADA? \_\_\_\_\_

FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
	NO ALIVE HEALTH		NO DECEASED CAUSE OF DEATH		NO DECEASED CAUSE OF DEATH
BROTHERS	NO ALIVE HEALTH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH
SISTERS	NO ALIVE HEALTH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH	NO DECEASED CAUSE OF DEATH
CHILDREN	NO ALIVE AGES & HEALTH	NO DECEASED AGES & CAUSE OF DEATH	NO DECEASED AGES & CAUSE OF DEATH	NO DECEASED AGES & CAUSE OF DEATH	NO DECEASED AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Tuberculosis     Heart disease     Stroke     High blood pressure     Nervous illness     Cancer     Bleeding tendency     Kidney disease  
 Diabetes     Allergy     Other

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD

Cancer     Asthma     Jaundice     Gonorrhea     Diabetes     Glaucoma     Heart trouble     Syphilis     Yeast infection  
 Rheumatic fever     Nervous disorder     Other     Bleeding tendencies     Tuberculosis     Pneumonia     Kidney disease

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?

No     Yes ► LIST

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

NO     Yes ► LIST

DO YOU USE TOBACCO NOW? IN THE PAST? TYPE AND DAILY AMOUNT HOW LONG?

No     Yes     No     Yes

DO YOU USE ALCOHOLIC BEVERAGES? TYPE WEEKLY AMOUNT HOW LONG?

No     Yes ►

DO YOU DRINK COFFEE? WEEKLY AMOUNT HOW LONG?

No     Yes ►

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

Smallpox     Tetanus     Typhoid     Polio     Influenza     Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENIAL (List any problems you have now)

INDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD PERIODS ARE \_\_\_\_\_ NUMBER OF PREGNANCIES \_\_\_\_\_ NUMBER OF MISCARRIAGES \_\_\_\_\_

Regular     Irregular

HAVE YOU TAKEN CORTISONE TYPE DRUGS? ORAL CONTRACEPTIVES? HAVE YOU RECEIVED A BLOOD TRANSFUSION?

No     Yes     No     Yes     No     Yes ► DATE

DRESSED WEIGHT \_\_\_\_\_ HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) \_\_\_\_\_ DATE \_\_\_\_\_

## RECTAL QUESTIONNAIRE

	<u>Yes</u>	<u>No</u>
<b>Do you have or have you had:</b>		
1. Bleeding from the rectum?	---	---
2. Pain in the anal area?	---	---
3. Soiling?	---	---
4. Itching in the anal area?	---	---
5. Frequent or constant urge to move bowels	---	---
 <b>A. Hemorrhoids:</b>		
1. How long have you had hemorrhoids?	---	---
2. Do they come out at time of a bowel movement?	---	---
3. Are you able to push the hemorrhoids back inside?	---	---
4. Does the hemorrhoid come out with standing and activity?	---	---
 <b>B. Bleeding per Rectum:</b>		
1. Is the bleeding aggravated by hard stool?	---	---
2. Have you not noticed black tarry stool?	---	---
3. Bleeding (Circle one)	---	---
<i>Small Amount</i>		
<i>Clots</i>		
<i>Staining</i>		
4. Is bleeding associated with bowel movements?	---	---
5. Is the blood mixed with stool?	---	---
 <b>C. Bowel Habits:</b>		
1. Constipation?	-	
2. Diarrhea?	---	---
3. Do you take a laxative daily?	---	---
4. Have you noticed a change in bowel habits?	---	---
5. Have you noticed excessive mucous discharge?	---	---
6. Stools (Circle one)		
<i>Uneven</i>		
<i>Soft</i>		
<i>Hard</i>		
7. Do you have to strain at time of bowel movements?	---	---
 <b>D. Pain:</b>		
Do you or have you had:		
1. Pain at time of bowel movement?	---	---
2. Pain without bowel movement?	---	---
3. Pain aggravated by hard stool?	---	---
4. How long have you had rectal pain? _____		

### **E. Soiling**

Do you or have you had:

- |  |     |     |
|--|-----|-----|
| 1. Difficulty in controlling your bowel movements? | --- | --- |
| 2. Soiling of your underpants?                     | --- | --- |

**F. Itching?**

- |  |     |     |
|--|-----|-----|
| 1. Is it severe?                       | --- | --- |
| 2. Is the itching limited to the anus? | --- | --- |
| 3. Is the itching worse at night?      | --- | --- |

**G. Past Medical Illness:**

- |  |     |     |
|--|-----|-----|
| 1. Have you had a similar problem in the past? | --- | --- |
| Previous Treatment (circle one)                |     |     |
| <i>Surgery</i>                                 |     |     |
| <i>Cream</i>                                   |     |     |
| <i>Suppository</i>                             |     |     |
| 2. Have you had a sigmoidoscopy done?          | --- | --- |
| If yes, when? _____                            |     |     |
| 3. Have you had a barium enema done?           | --- | --- |
| If yes, when? _____                            |     |     |
| 4. Are you taking any blood thinners?          | --- | --- |
| If yes, when? _____                            |     |     |

**H. Personal History:**

Do you or have you had:

- |   |     |     |
|---|-----|-----|
| 1. Straining at time of bowel movement? | --- | --- |
| 2. Anal Intercourse?                    | --- | --- |

**I. Family History:**

Does your family have a history of:

- |                    |     |     |
|--------------------|-----|-----|
| 1. Colon Cancer?   | --- | --- |
| If yes, Who? _____ |     |     |
| 2. Rectal Cancer?  | --- | --- |
| If yes, Who? _____ |     |     |
| 3. Hemorrhoids?    | --- | --- |
| If yes, Who? _____ |     |     |