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Name: _____ Age: _____ Date: _____

Who referred you for this examination? _____

Have you ever had a sigmoidoscopy or colonoscopy? _____

If so, when? _____ What doctor? _____

Have you had any significant change in your bowel habits? _____

Do you regularly have diarrhea or constipation? _____

Do you have any rectal bleeding? _____

If so, is it bright red, burgundy, or maroon? _____

Do you see blood with the stool, on the toilet, or associated with a mucous discharge? _____

Do you have a family history of: Colon Cancer? _____

Colon Polyps? _____

Ulcerative Colitis? _____

Crohn's Disease? _____

If so, who? _____

Do you have a personal history of: Colon Cancer? _____

Colon Polyps? _____

Breast, Uterine, Ovarian, or Cervical Cancer? _____

Please add any additional information, if pertinent.

Please list the name(s) of doctor(s) that you would like us to send a report.

