**SURGICAL SPECIALISTS OF COLORADO, P.C.**

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 Suite 200 Suite 290 Suite 2400

 Golden, Co 80401 Wheat Ridge, Co 80033 Aspen, Co 81611

 303-940-8200 303-467-1467 970-429-4267

Date:

Patient Name:

Date of Birth: Age: Height: Weight:

**TO GIVE YOU THE BEST POSSIBLE MEDICAL TREATMENT AND CARE, WE MUST OBTAIN A COMPLETE MEDICAL HISTORY. ANSWERING THIS QUESTIONNAIRE WILL ASSIST YOUR SURGEON.**

**Referring Physician**: **Primary Care Physician/Provider**:

What is the reason for this visit?

Have you been seen in our office before? **** YES **** NO If yes, date:

List other Doctors you are seeing and why:

**PREFERRED LANGUAGE**: **RACE**: **ETHNICITY**:

 **** English **** French **** Asian **** Caucasian **** Black or African American **** Hispanic or Latino

 **** German **** Vietnamese **** American Indian or Alaskan Native **** Non-Hispanic or Non-Latino

 **** Italian **** Mandarin **** Pacific Islander or Hawaiian **** Unknown

 **** Spanish

**YOUR MEDICAL HISTORY - Check all that apply**:

**** Heart Attack ****High Blood Pressure **** AIDS **** Asthma

**** Stroke **** Blood Clots **** HIV ****MRSA

**** Diabetes **** Hepatitis

**** Oxygen Required Liters/min **** Cancer List type:

**YOUR PAST SURGERIES AND DATES:**

**FAMILY MEDICAL HISTORY: Relationship**

Diabetes **** YES **** NO

Cardiac Problems **** YES **** NO

Bleeding Problems **** YES **** NO

Cancer **** YES **** NO

 Type:

High Blood Pressure **** YES **** NO

Reaction to anesthesia **** YES **** NO

Parent’s current age, if alive: Mother Father

If deceased, age & cause of death: Mother Father Cause:

**PATIENT NAME:**

**MEDICATIONS**

 **PRESCRIBED MEDICATIONS**   **OVER THE COUNTER SUPPLEMENTS & HERBALS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NAME | DOSE | # YOU TAKE PER DAY | NAME OF ITEM |  STRENGTH | # YOU TAKE PER DAY |
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**ALLERGY TO ANY MEDICATIONS**: **** YES **** NO If YES, Medication(s) Reaction:

**DO YOU HAVE A LATEX ALLERGY?** **** YES **** NO Type of Reaction:

**DO YOU TAKE ANTIBIOTICS PRIOR TO PROCEDURES**? **** YES **** NO If YES, Name of Antibiotic

**DO YOU TAKE ANY BLOOD THINNERS**? **** YES **** NO

**** Aspirin **** Advil/Anti-Inflammatory Meds **** Plavix **** Pradaxa **** Coumadin **** Other:

**DATE OF YOUR LAST COLONOSCOPY/ENDOSCOPY:**  **DATE:\_\_\_\_\_\_\_\_\_\_ RESULTS:**

**DATE OF YOUR LAST MAMMOGRAM:**  **DATE:\_\_\_\_\_\_\_\_\_\_RESULTS:**

**AGE OF FIRST PERIOD:**  **ONSET OF MENOPAUSE:**

**DATE OF LAST EKG:**

**Date of last Flu Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Approx.) Date of last Pneumonia Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Approx.)**

**SOCIAL HISTORY:**

Do you use alcohol? **** YES **** NO If yes, how often and how much

Do you smoke? **** YES **** NO If yes, packs/day  Chew tobacco? **** YES **** NO If yes, amount/day \_\_\_\_\_ Year Started

Have you stopped smoking or chewing tobacco? ****YES **** NO If yes, DATE QUIT?

Do you have a history of sexually transmitted diseases? **** YES **** NO

Do you use recreational drugs? **** YES **** NO What kind? How often

**** Married **** Partner **** Single **** Other

# of Children # of Pregnancies Currently pregnant? **** YES **** NO

**** Retired **** Working What is or was your occupation?

Living situation: **** Home **** Apartment **** Assisted Living **** Other:

**PATIENT NAME:**

**REVIEW OF SYSTEMS (Check only those that apply to you):**

**IF NONE APPLY PLEASE MARK HERE: **

**GENERAL:** **GASTROINTESTINAL:** **BREAST: CARDIOVASCULAR:**

**** Fever **** Abdominal Pain **** Left Breast Lump **** Chest pain

**** Anorexia **** Nausea/Vomiting **** Right Breast Lump **** Palpitations

**** Weight loss **** Diarrhea **** Nipple Discharge **** Syncope

 **** Constipation **** Bloody Discharge from Nipple **** Peripheral Edema

 **** Change in Bowel Habits **** Breast Pain

 **** Black Tarry Stools **** Abnormal Mammogram

 **** Bloody Stools **** Breast Enlargement

 **** Jaundice

 **** Gas/Bloating

 **** Indigestion/Heartburn

 **** Difficulty Swallowing

 **** Painful Swallowing

**RESPIRATORY:**  **VASCULAR: GENITOURINARY: WOUND:**

**** Cough **** Varicose Veins **** Vaginal Discharge **** Wound Redness

**** Shortness of Breath **** Leg Swelling **** Incontinence **** Wound Discharge

**** Cough up blood **** Redness **** Painful Urination **** Wound Pain

**** Wheezing **** Coolness **** Blood in Urine **** Opening of Wound

**** Pleuritic Chest Pain **** Pain in Legs with Walking **** Urinary Frequency **** Purulent Discharge

 **** Resting Leg Pain **** Abnormal Vaginal Bleeding **** Bleeding from Wound

 **** Pain at Night in Legs **** Pelvic Pain

 **** Blue Toe(s) **** Pregnancy

**SKIN: NEUROLOGIC: PSYCHIATRIC: ENDOCRINE:**

**** Suspicious Lesion **** Paralysis **** Depression **** Cold Intolerance

**** New skin Lesion **** Numbness **** Anxiety **** Heat Intolerance

**** Changing Mole (s) **** Seizures **** Nervousness **** Excessive Thirst

**** Rash **** Frequent Headaches **** Suicidal Ideation **** Excessive Eating

**** Itching **** Hallucinations **** Excessive Urination

**** History of Skin Cancer **** Paranoia **** Unusual Weight change

 **** Phobia

 **** Confusion

**BLOOD: MUSCULOSKELETAL: OTHER:**

**** Abnormal Bruising **** Back Pain **** Stoma Redness

**** Bleeding **** Sciatica **** Pain Around Stoma

**** Enlarged Lymph Nodes **** Arthritis **** Discharge from Stoma

 **** Pain from Venous Catheter

 **** Redness at Vascular Access Site

 **** Purulent Drainage from Vascular Access Site

**PATIENT NAME:**

**MY MEDICAL HISTORY QUESTIONNAIRE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:**

Date:

Signed:

 (Patient or Guardian)

**--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**MEDICAL HISTORY REVIEWED WITH THE PATIENT AND/OR GUARDIAN WITHIN 6 MONTHS OD LAST VISIT:**

Patient Signature: Date:

Reviewed by:

 (RN, LPN, MA)

Signed by:

 (M.D.)

