SURGICAL SPECIALISTS OF COLORADO, P.C.

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303-940-8200	303-467-1467	720-321-8470	720-376-0554	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:
☐ English ☐ French
☐ German ☐ Vietnamese
☐ Italian ☐ Mandarin
☐ Spanish

RACE:
☐ Asian ☐ Caucasian ☐ Black or African American
☐ American Indian or Alaskan Native
☐ Pacific Islander or Hawaiian

ETHNICITY:
☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ Unknown

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

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 <u>you</u>):

IF NONE APPLY PLEASE MARK HERE: ☐

GENERAL:
- ☐ Fever
- ☐ Anorexia
- ☐ Weight loss

GASTROINTESTINAL:
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Black Tarry Stools
- ☐ Bloody Stools
- ☐ Jaundice
- ☐ Gas/Bloating
- ☐ Indigestion/Heartburn
- ☐ Difficulty Swallowing
- ☐ Painful Swallowing

BREAST:
- ☐ Left Breast Lump
- ☐ Right Breast Lump
- ☐ Nipple Discharge
- ☐ Bloody Discharge from Nipple
- ☐ Breast Pain
- ☐ Abnormal Mammogram
- ☐ Breast Enlargement

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Syncope
- ☐ Peripheral Edema

RESPIRATORY:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Cough up blood
- ☐ Wheezing
- ☐ Pleuritic Chest Pain

VASCULAR:
- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Redness
- ☐ Coolness
- ☐ Pain in Legs with Walking
- ☐ Resting Leg Pain
- ☐ Pain at Night in Legs
- ☐ Blue Toe(s)

GENITOURINARY:
- ☐ Vaginal Discharge
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Abnormal Vaginal Bleeding
- ☐ Pelvic Pain
- ☐ Pregnancy

WOUND:
- ☐ Wound Redness
- ☐ Wound Discharge
- ☐ Wound Pain
- ☐ Opening of Wound
- ☐ Purulent Discharge
- ☐ Bleeding from Wound

SKIN:
- ☐ Suspicious Lesion
- ☐ New skin Lesion
- ☐ Changing Mole (s)
- ☐ Rash
- ☐ Itching
- ☐ History of Skin Cancer

NEUROLOGIC:
- ☐ Paralysis
- ☐ Numbness
- ☐ Seizures
- ☐ Frequent Headaches

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Suicidal Ideation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobia
- ☐ Confusion

ENDOCRINE:
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Eating
- ☐ Excessive Urination
- ☐ Unusual Weight change

BLOOD:
- ☐ Abnormal Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes

MUSCULOSKELETAL:
- ☐ Back Pain
- ☐ Sciatica
- ☐ Arthritis

OTHER:
- ☐ Stoma Redness
- ☐ Pain Around Stoma
- ☐ 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.)