

# SURGICAL SPECIALISTS OF COLORADO, P.C.

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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
- Unknown

**ETHNICITY:**

- Hispanic or Latino
- Non-Hispanic or Non-Latino

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

- Heart Attack
- Stroke
- Diabetes
- Oxygen Required Liters/min \_\_\_\_\_
- High Blood Pressure
- Blood Clots
- Hepatitis
- Cancer List type: \_\_\_\_\_
- AIDS
- HIV
- Asthma

**YOUR PAST SURGERIES AND DATES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

- Diabetes  YES  NO
- Cardiac Problems  YES  NO
- Bleeding Problems  YES  NO
- Cancer  YES  NO

**Relationship**

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 you):**

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)

**I HAVE REVIEWED THIS MEDICAL HISTORY WITH THE PATIENT AND/OR GUARDIAN:**

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_  
(RN, LPN, MA)

Signed by: \_\_\_\_\_  
(M.D.)

**MEDICAL HISTORY REVIEWED WITHIN 6 MONTHS OF LAST VISIT.**

Date: \_\_\_\_\_

Patient/Guardian Initials: \_\_\_\_\_

**I HAVE REVIEWED THIS MEDICAL HISTORY WITH THE PATIENT AND/OR GUARDIAN:**

Reviewed by: \_\_\_\_\_  
(RN, LPN, MA Initials)

M.D. Initials: \_\_\_\_\_