

SURGICAL SPECIALISTS OF COLORADO, P.C.

Krista Antenucci, DO • Juhi Asad, DO • Bryan Baer, MD • Jennifer Bocker, MD • Elizabeth Brew, MD • Rachel Caiafa, MD • Ashley Davis, MD
Lesley Fraser, MD • Katayun Irani, MD • Karen S. Johnson, MD • Rebecca Knight, MD • Joseph Livengood, MD • Robert Madayag, MD • Charles Mains, MD
Robert Marshall, MD • Vance Mitchell, MD • Patrick Offner, MD • Gregory Pinson, MD • Edward Pulido, MD • Franco Rea, MD • Matthew Reynolds, DO
Fred Seale, MD • Eben Strobos, MD • Rebecca Vogel, MD • Bruce Waring, MD • Rebecca Wiebe, MD • Christopher Zaw-Mon, MD

400 Indiana St, Suite 200 3455 Lutheran Pkwy, Suite 290 1721 E 19th Ave, Suite 454 1000 Rush Drive 0401 Castle Creek Road, Suite 2400
Golden, Co 80401 Wheat Ridge, Co 80033 Denver, Co 80218 Salida, Co 81201 Aspen, Co 81611
303-940-8200 303-467-1467 303-860-7099 719-530-2000 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:

- 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)

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.)
