SURGICAL SPECIALISTS OF COLORADO, P.C.

400 Indiana Street
Suite #200
Golden, CO 80401
Phone: 303-940-8200

200 W County Line Road
Suite #135
Highlands Ranch, CO 80129
Phone: 303-940-8200

Date of appointment: _____

Patient Name: _____ Prefer to be called: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Gender: _____ Male _____ Female _____ Transgender _____ Nonbinary _____ Prefer not to answer

Pharmacy: _____ Address/Cross Streets: _____

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: _____

_____

_____

YOUR MEDICAL HISTORY - Check all that apply:

☐ Heart Attack	☐ High Blood Pressure	☐ AIDS/HIV	☐ Asthma
☐ Stroke	☐ Blood Clots	☐ MS	☐ MRSA
☐ Diabetes	☐ Hepatitis	☐ Lupus	☐ COPD
☐ STD	☐ Cancer List type: _____		
☐ Oxygen Required Liters/min _____	☐ Other: _____		

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 _____ Cause: _____

Father _____ Cause: _____

PATIENT NAME: _____

MEDICATIONS

PRESCRIBED MEDICATIONS — OVER THE COUNTER SUPPLEMENTS & HERBALS

NAME OF MEDICATION	STRENGHT	# YOU TAKE PER DAY	NAME OF MEDICATION	STRENGTH	# YOU TAKE PER DAY

ALLERGY TO ANY MEDICATIONS: ☐ YES ☐ NO If YES, Medication(s) and Reaction:_____

_____

DO YOU HAVE A LATEX ALLERGY? ☐ YES ☐ NO If yes, Type of Reaction: _____

DO YOU TAKE ANY BLOOD THINNERS? ☐ YES ☐ NO
☐ Aspirin ☐ Coumadin ☐ Advil/Anti-Inflammatory Meds ☐ Eliquis ☐ Plavix ☐ Pradaxa ☐ Xarelto ☐ Other: _____

DATE OF YOUR MOST RECENT: ☐ COLONOSCOPY ☐ COLOGUARD ☐ ENDOSCOPY

DATE: _____ RESULTS: _____

DATE OF YOUR MOST RECENT MAMMOGRAM: DATE:_____ RESULTS: _____

AGE OF FIRST PERIOD: _____ ONSET OF MENOPAUSE: _____

DATE OF YOUR MOST RECENT EKG: _____

Date of your most recent Flu Vaccine: _____ (Approx.) Date of your most recent Pneumonia Vaccine: _____(Approx.)

SOCIAL HISTORY:
Do you use alcohol? ☐ YES ☐ NO If yes, how many drinks per week _____

Do you smoke? ☐ YES ☐ NO If yes, packs/day _____ Year Started _____

Do you 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 use recreational drugs? ☐ YES ☐ NO What kind? _____ How often _____

☐ Married/Partnered ☐ Single ☐ Other _____

# of Children _____ # of Pregnancies _____ Currently pregnant? ☐ YES ☐ NO

☐ Retired ☐ Working What is or was your occupation? _____

Living situation: ☐ Live alone or with family/friends ☐ Assisted Living ☐ Group Home ☐ Hotel/Motel ☐ Homeless
☐ 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.)