Health ONE Rocky Mountain Surgical Specialists Physician Care℠

PATIENT INFORMATION (Please Print)

Patient History

Patient Name: _____

Date of Birth _____/_____/_____ Age _____ **Height** _____ **Weight**_____

Marital Status: Married☐ Partner☐ Single☐ Divorced☐ Widowed☐

Gender Identity (please circle): Male☐ Female☐ Transgender Female to Male☐ Transgender Male to Female☐ Genderqueer☐
Choose not to disclose☐

Preferred Pronouns: She/Her☐ He/Him☐ They/Them☐

Please describe the nature of your issue:

_____

_____

***PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY),* or if none please circle: None☐**
If you need more space for your medications, please provide a list on a separate sheet

Name, dose (i.e., 2 mg, 60 mg, etc)	**Frequency** (i.e. twice daily, at bedtime)	**Problem being treated Prescribing Doctor**

ALLERGIES:

Are you allergic to ANY medication, food, or non-medications (such as pollen, etc.)? ☐ **No** ☐ **Yes**

If yes, please list below. Name of Medication / Food / Agent Type of Reaction, i.e. rash, breathing problems, swelling, etc

_____ _____

_____ _____

Metal Allergy: ☐ **Y or** ☐ **N** **Latex Allergy**: ☐ **Y or** ☐ **N**

PAST MEDICAL HISTORY

Please ✓ box next to any condition with which YOU have been diagnosed, or list other:

Medical	**Medical**	**Neurological**	**Pertinent to Surgery**
☐ **None**	☐ GERD / Reflux	☐ Aneurysm	☐ Anticoagulation
☐ Anemia	☐ Glaucoma	☐ CVA/Stroke	☐ Bleeding Disorder
☐ Anxiety	☐ Heart Disease	☐ Brain Tumor	☐ Chronic Pain
☐ Asthma	☐ Hepatitis	☐ Hydrocephalus	☐ Clotting Disorder
☐ Atrial Fibrillation	☐ HIV	☐ Migraines	☐ DVT
☐ Autoimmune Disorder	☐ High cholesterol/lipids	☐ Multiple Sclerosis	☐ Hemophilia
☐ Enlarged Prostate	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Narcotic use > 6 mo
☐ Cancer – Breast	☐ Irritable bowel disease	☐ Peripheral Neuropathy	☐ Anesthesia Problems
☐ Cancer – Lung	☐ Myocardial infarction	☐ Pituitary Tumor	☐ Pulmonary Embolism
☐ Cancer – Renal	☐ Nasal Allergies	☐ Seizure Disorder	☐ Other:
☐ Cancer – Colon	☐ Osteoarthritis	☐ Spinal Cord Injury	
☐ Cancer – Prostate	☐ Osteoporosis	☐ TIA	
☐ COPD	☐ Renal Disease	☐ Traumatic Brain Injury	
☐ Depression	☐ Rheumatoid Arthritis	☐ Trigeminal Neuralgia	
☐ Diabetes – Type I	☐ Thyroid Disease	☐ Other:	
☐ Diabetes – Type 2	☐ Vision Loss		
☐ Fibromyalgia	☐ Other:		

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SURGERIES:

Have you ever had surgery? ☐ **No** ☐ **Yes**

If **yes**, list name / type of surgeries and when they were done.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY

Please place ✓ in box and indicate which a member of your immediate family (i.e., mother, father, brother, sister) has been diagnosed:

☐ *Unknown* ☐ *Adopted* ☐ *None*

☐ FH Alcoholism	☐ FH Breast Cancer	☐ FH High Blood Pressure	☐ FH Ovarian Cancer
☐ FH Anemia	☐ FH Cervical Cancer	☐ FH High Cholesterol	☐ FH Psychiatric Care
☐ FH Angina	☐ FH Colon Cancer	☐ FH Kidney Disease	☐ FH Respiratory Disease
☐ FH Arthritis	☐ FH Depression	☐ FH Liver Disease	☐ FH Seizures
☐ FH Asthma	☐ FH Diabetes	☐ FH Lung Cancer	☐ FH Severe Allergies
☐ FH Birth Defects	☐ FH Growth Problems	☐ FH Skin Cancer	☐ FH Stroke
☐ FH Blood Clots	☐ FH Headaches	☐ FH Osteoporosis	☐ FH Thyroid Disease
☐ FH Bowel Disease	☐ FH Heart Disease	☐ FH Other Cancer	☐ FH Uterine Cancer

SOCIAL HISTORY

Do you currently smoke / use tobacco in any form? ☐ **No** ☐ **Yes**
If yes, do you smoke or chew tobacco: _____
If yes, have you tried a smoking cessation or counseling program_____

Do you have a history of smoking/tobacco use? … ☐ **No** ☐ **Yes**
If yes, when did you quit? _____

Do you currently drink alcohol? …… ☐ **No** ☐ **Yes**
If yes, please list how much a week:_____

Do you have history of alcohol abuse? …….... ☐ **No** ☐ **Yes**
If yes, when did you quit? _____

Do you currently use any recreational drugs: ……... ☐ **No** ☐ **Yes**
If yes, what type and how often: _____

PREVENTATIVE CARE

Have you had a colonoscopy (over age 55)? ☐ ☐ ***Y or N*** ***When?***_____ ***Results?***_____

Have you had a pneumonia vaccine (over age 65)? ☐ ☐ ***Y or N*** ***When?***_____

Have you had any falls over the past year? ☐ ☐ ***Y or N*** ***How many?***_____

Did you sustain an injury?:_____

Cause of fall? (Medical condition, environment- stairs, loose rug, etc)_____

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Female Patients ONLY:

Date of last menstruation (approximate): _____

Pregnant: Yes ☐ No ☐ Unsure ☐ Prefer not to answer ☐

Breast feeding: Yes ☐ No ☐

Primary Care Physician Information

Name:_____ Phone: _____

Address: _____

Pharmacy Information:

Name: _____ Phone :_____

Address:_____

How did you hear about us? Circle any that apply:

☐ Insurance Company ☐ Friend/Family/Word of Mouth ☐ Internet Search Engine ☐ Physician Referral ☐ Referral Mailers

Physician Referral (please specify) _____

Other:_____