NORTHERN COLORADO SURGICAL ASSOCIATES, P.C.

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OFFICE VISIT DATE: _____

Last Name: _____ First Name: _____ M.I.: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ Age: _____ Height: _____ Weight: _____

PREFERRED PHARMACY: _____

REASON FOR YOUR VISIT TODAY: _____

DRUG ALLERGIES: _____

_____

MEDICAL HISTORY (include serious illnesses, injuries, and all current medical conditions):

_____

_____

SURGICAL HISTORY (type/date): _____

_____

_____

FAMILY MEDICAL HISTORY: ❑ Family History Unknown ❑ Adopted

RELATIONSHIP	Alive	Deceased	PLEASE LIST AND PAST MEDICAL HISTORY
Mother			
Father			
Sister			
Brother			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Maternal Aunt			
Maternal Uncle			
Paternal			
Paternal			
Other			

SOCIAL HISTORY

TOBACCO USE:

Do you currently use tobacco products or have you in the past? _____ Quit Date _____

Number of years tobacco has been used? _____ Amount of tobacco products used per day: _____

ALCOHOL/DRUG USE:

Do you currently use illicit drugs, if so please specify: _____

Do you currently drink alcohol? _____ Number/type of drinks per week: _____

SOCIOECONOMIC HISTORY

Are you currently employed, retired, or disabled? _____

Location of employment? _____

Marital Status: _____ Spouse's Name: _____ Number of Children: _____

FEMALES ONLY:

Number of pregnancies: _____ Number of abortions: _____ Number of Miscarriages: _____

MEDICATIONS

Please list all current medications (prescription and over the counter), vitamins, and supplements along with frequency and dosage:

_____

_____

_____

_____

_____

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_____

REVIEW OF SYSTEMS

CONSTITUTIONAL

Weight Loss/Gain	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Fever	❑ Yes	❑ No
Sweats	❑ Yes	❑ No

EYES

Glasses/Contacts	❑ Yes	❑ No
Pain	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Blind Spots	❑ Yes	❑ No
Blind	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No

EAR/NOSE/THROAT

Hearing Loss	❑ Yes	❑ No
Ringing in Ears	❑ Yes	❑ No
Ear Pain	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Nasal Stuffiness	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Hoarseness	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Murmur	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Fainting Spells	❑ Yes	❑ No
Difficulty Lying Flat	❑ Yes	❑ No
Swollen Ankles	❑ Yes	❑ No

HEME/LYMPH

Easy Bleeding/Bruising	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No
Enlarged Glands	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No

GASTROINTESTINAL

Nausea/Vomiting	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Abdominal Pain	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No

GASTROINTESTINAL *(continued)*

Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Change in BMs	❑ Yes	❑ No
Pain in BMs	❑ Yes	❑ No
Rectal Bleeding	❑ Yes	❑ No
Regurgitation	❑ Yes	❑ No
Heartburn or Indigestion	❑ Yes	❑ No
Trouble with Spicy Foods	❑ Yes	❑ No
Burning Stomach	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Ever have Hepatitis	❑ Yes	❑ No
Black, Tarry Stools	❑ Yes	❑ No
Ulcer Problems	❑ Yes	❑ No
Food Gets Stuck in Your Chest When You Swallow	❑ Yes	❑ No

GENITOURINARY

Urgency	❑ Yes	❑ No
Frequency	❑ Yes	❑ No
Night-Time Frequency	❑ Yes	❑ No
Burning	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Decreased Stream	❑ Yes	❑ No
Kidney Stones	❑ Yes	❑ No
Sexually Transmitted Disease	❑ Yes	❑ No
Abnormal Discharge	❑ Yes	❑ No
Leaking Urine	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain/Swelling	❑ Yes	❑ No
Muscle Pain	❑ Yes	❑ No
Neck/Back Pain	❑ Yes	❑ No
Gout	❑ Yes	❑ No
Varicose Veins	❑ Yes	❑ No

NEUROLOGICAL

Headaches	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Tremors	❑ Yes	❑ No
Weakness/Paralysis	❑ Yes	❑ No
Numbness/Tingling	❑ Yes	❑ No
Speech Difficulty	❑ Yes	❑ No
Memory Loss	❑ Yes	❑ No
Stroke	❑ Yes	❑ No

ENDOCRINE

Hair Loss	❑ Yes	❑ No
Heat/Cold Intolerance	❑ Yes	❑ No
Change in Nails	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Blood Sugar Problems	❑ Yes	❑ No

PSYCHIATRIC

Anxiety/Depression	❑ Yes	❑ No
Mood Swings	❑ Yes	❑ No
Difficulty Sleeping	❑ Yes	❑ No

RESPIRATORY

Chronic Cough	❑ Yes	❑ No
Cough Blood	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
at Rest	❑ Yes	❑ No
with Exertion	❑ Yes	❑ No
Asthma/Emphysema	❑ Yes	❑ No

SKIN

Rash/Sores	❑ Yes	❑ No
Lesions	❑ Yes	❑ No
Itching/Burning	❑ Yes	❑ No

ALLERGIC/IMMUNE

Hay Fever	❑ Yes	❑ No
Eczema/Hives	❑ Yes	❑ No

BREASTS

Lumps in Breasts	❑ Yes	❑ No
Had Surgery on Breasts	❑ Yes	❑ No
Have Bloody Discharge	❑ Yes	❑ No
Had Skin Dimpling	❑ Yes	❑ No

Date of last mammogram _____

_____

Where was it taken _____

_____

_____

_____

Reviewed by: _____ ***Date:*** _____