_____M.A. _____M.D.

ROCKY MOUNTAIN SURGICAL ASSOCIATES, P.C.

PATIENT HEALTH HISTORY

Name: _____Date: _____
Last First MI

Reason for visit: _____

PLEASE INDICATE AND EXPLAIN ANY PERSONAL MEDICAL HISTORY BELOW:

Yes	No	
☐	☐	**Eyes/Ears/Throat _____**
☐	☐	**Lungs _____**
☐	☐	**Heart _____**
☐	☐	**High Blood Pressure _____**
☐	☐	**Stomach Ulcers _____**
☐	☐	**Bowel/Intestinal _____**
☐	☐	**Yellow Jaundice/Cirrhosis/Liver Disease _____**
☐	☐	**Kidney/Bladder _____**
☐	☐	**Diabetes _____**
☐	☐	**Thyroid _____**
☐	☐	**Blood Clots _____**
☐	☐	**Bleeding Problems _____**
☐	☐	**Seizures/Strokes _____**
☐	☐	**Psychiatric, e.g. depression _____**
☐	☐	**Weight loss/gain _____**
☐	☐	**Alcohol (drinks per week) _____**
☐	☐	**Tobacco (packs per day) _____**
☐	☐	**Cancer _____**
☐	☐	**Recreational Drug Use _____**
☐	☐	**Is it possible that you are pregnant? _____**
☐	☐	**Hepatitis _____**
☐	☐	**HIV _____**
☐	☐	**Colonoscopy Date: _____Results: _____**

Prior Surgeries (Including Minor Procedures):

_____Date: _____
_____Date:_____
_____Date: _____
_____Date:_____
_____Date: _____
_____Date:_____

Problems with Anesthesia (describe): _____

Name: _____Date: _____
Last First MI

Current Medication (include over the counter medication, herbal supplements, diet supplements)

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

_____ Reaction _____
_____ Reaction _____
_____ Reaction _____

FAMILY MEDICAL HISTORY
Please describe any illnesses that run in your family
_____
_____

Is there any other information you would like us to know?
_____
_____
_____

PATIENT SIGNATURE _____ DATE _____