1231 Lake Plaza Drive| Colorado Springs, CO | 80906 | (719) 955-0648

## PATIENT INFORMATION

Name: _____ Date: ____/_____/_____

SS: _____ - ____ - _____ Sex: M / F Date of Birth: ____/_____/_____

Marital Status: Married / Partner / Single / Widowed Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer Name: _____ Work Phone: (_____) _____-_____

Emergency Contact Name: _____ Phone: (_____) _____-_____

Relationship to Emergency Contact: _____

Do you have a "Living Will" or an "Advance Directive? Yes_____ No_____

How did you hear about our office? Referred by: _____

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Please indicate whether you have a history of any of the following **common conditions**:

| | | | |
|---|---|---|---|
| **Constitutional** | **Cardiovascular** | **Musculoskeletal** | **Hematologic** |
| ❑ Overweight | ❑ Hypertension | ❑ Degenerated Disc | ❑ Anemia |
| ❑ Obese | ❑ Hypotension | ❑ Bulging/Herniated Disc | ❑ Clotting Disorder |
| **Eyes** | ❑ Hyperlipidemia | ❑ Osteoarthritis | **Allergic** |
| ❑ Wear Corrective Lenses | ❑ Heart Disease | ❑ Rheumatoid Arthritis | ❑ Autoimmune Disease |
| ❑ Glaucoma | ❑ Myocardial Infarction | ❑ Gout | **Men** |
| ❑ Macular Degeneration | ❑ Atrial Fibrillation | ❑ Osteoporosis | ❑ Erectile Dysfunction |
| ❑ Cataracts | ❑ Stroke | **Neurologic** | ❑ Enlarged Prostate |
| **Ears** | ❑ Varicose Veins | ❑ Peripheral Neuropathy | **Female** |
| ❑ Hearing Aid | ❑ Deep Vein Thrombosis | ❑ Vertigo | ❑ Breast Cancer |
| **Respiratory** | ❑ Pulmonary Embolism | ❑ Epilepsy | **Psychiatric** |
| ❑ Asthma | **Gastrointestinal** | ❑ Multiple Sclerosis | ❑ Dementia |
| ❑ COPD | ❑ GERD/Heartburn | ❑ Parkinson's Disease | ❑ Psychiatric Care |
| ❑ On Oxygen | ❑ Ulcer | **Endocrine** | ❑ Psychiatric Illness |
| ❑ Bronchitis | ❑ Diverticulitis | ❑ Hypoglycemia | ❑ Alcoholism |
| | ❑ Liver Disease | ❑ Diabetes I (Childhood) | |
| | **Genitourinary** | ❑ Diabetes II (Adult Onset) | |
| | ❑ Kidney Disease | ❑ Hypothyroidism | |
| | ❑ Kidney Stones | ❑ Hyperthyroidism | |

Have you ever had **cancer**? ❑No. ❑Yes. What kind(s) if yes? _____

Have you ever had a **broken bone**? ❑No. ❑Yes. Which bone, what side? _____

Please list any **other conditions** in your health history that are not included above:

_____

_____

Please indicate whether you have a history of any of the following **common surgeries**:

| | | | |
|---|---|---|---|
| ❑ Cataract Surgery | ❑ Gall Bladder Removal | ❑ Left Hip Replacement | ❑ Fracture Surgery |

| | | | |
|---|---|---|---|
| ❑ Tonsillectomy | ❑ Colon Surgery | ❑ Right Hip Replacement | ❑ Thyroidectomy |
| ❑ Stent | ❑ Bariatric Procedure | ❑ Left Knee Replacement | ❑ Mastectomy |
| ❑ Pacemaker | ❑ Cervical Discectomy | ❑ Right Knee Replacement | ❑ Lumpectomy |
| ❑ Angioplasty | ❑ Cervical Fusion | ❑ Left Knee Arthroscopic | ❑ C-Section |
| ❑ Coronary Bypass | ❑ Lumbar Fusion | ❑ Right Knee Arthroscopic | ❑ Prostatectomy |
| ❑ Appendectomy | ❑ Lumbar Laminectomy | ❑ Left Ankle Surgery | ❑ Hysterectomy |
| | ❑ Lumbar Discectomy | ❑ Right Ankle Surgery | |

Please list any **other surgeries** in your health history that are not included above:

_____

_____

**Medications:** ❑ Check if you brought a complete list of medications.
Please list your medications below if you did not bring a complete list.

_____

**Allergies:** Do you have allergies to any of the following? ❑No allergies.
❑Birds ❑Avian Proteins ❑Chicken ❑Eggs ❑Feathers ❑Shellfish ❑Iodine ❑Contrast media/dye ❑Cortisone ❑Lidocaine ❑Xylocaine ❑Bupivicaine ❑Penicillin ❑Codeine ❑Latex
❑ Check if you brought a list of allergies. Please list any other allergies below if you did not bring a list.

_____

**Constitutional**
- ❒ Fever
- ❒ Fatigue
- ❒ Sleep Issues
- ❒ Loss of Appetite
- ❒ Excessive Hunger
- ❒ Weight Gain
- ❒ Unexplained Weight Loss
- ❒ Night Sweats
- ❒ Check here if none of above.

**Eyes**
- ❒ Wear Glasses or Contacts
- ❒ Blurred Vision
- ❒ Double Vision
- ❒ Pain
- ❒ Redness
- ❒ Halos/Flashes
- ❒ Check here if none of above.

**Ears**
- ❒ Ringing in Ears (Tinnitus)
- ❒ Pressure in Ears
- ❒ Pain in the Ear
- ❒ Ear Discharge
- ❒ Hearing Loss
- ❒ Check here if none of above.

**Mouth, Nose & Throat**
- ❒ Stuffiness (Nasal
- ❒ Nose Bleeds (Epistaxis)
- ❒ Sinus Problems
- ❒ Dry Mouth
- ❒ Throat Sores
- ❒ Hoarseness
- ❒ Sore Throat

**Respiratory**
- ❒ Shortness of Breath
- ❒ Cough
- ❒ Congestion
- ❒ Sputum
- ❒ Wheezing
- ❒ Check here if none of above.

**Cardiovascular**
- ❒ Chest Pain
- ❒ Chest Tightness
- ❒ Palpitations/Skipped Beats
- ❒ Heart Rhythm Problems
- ❒ Swelling in the Legs (Edema)
- ❒ Fainting (Syncope)
- ❒ Check here if none of above.

**Gastrointestinal**
- ❒ Nausea
- ❒ Vomiting
- ❒ Abdominal Pain
- ❒ Diarrhea
- ❒ Constipation
- ❒ Bowel Control Problem
- ❒ Indigestion
- ❒ Blood in Stool
- ❒ Heartburn
- ❒ Check here if none of above.

**Genitourinary**
- ❒ Incontinence
- ❒ Frequent Urination
- ❒ Urgent Urination
- ❒ Painful Urination
- ❒ Excessive Urination
- ❒ Blood in Urine

**Skin/Integumentary**
- ❒ Rash
- ❒ Skin Sores or Ulcers
- ❒ Itching
- ❒ Dry Skin
- ❒ Hair or Nail Changes
- ❒ Check here if none of above.

**Musculoskeletal**
- ❒ Joint Swelling
- ❒ Redness of Joints
- ❒ Stiffness
- ❒ Muscle Spasms
- ❒ Neck Pain
- ❒ Shoulder or Arm Pain
- ❒ Low Back Pain
- ❒ Hip Pain
- ❒ Ankle Pain
- ❒ Check here if none of above.

**Neurologic**
- ❒ Headaches
- ❒ Migraines
- ❒ Dizziness
- ❒ Nerve Pain
- ❒ Tingling or Numbness
- ❒ Seizures
- ❒ Tremor
- ❒ Difficulty of Speech
- ❒ Balance Problems
- ❒ Frequent Falls
- ❒ Coordination Problems
- ❒ Check here if none of above.

**Endocrine**
- ❒ Heat/Cold Insensitivity

**Hematologic/Lymphatic**
- ❒ Ease of bruising
- ❒ Ease of bleeding
- ❒ Swollen Lymph Nodes
- ❒ Check here if none of above.

**Allergic/Immunologic**
- ❒ Environmental Allergies
- ❒ Food Sensitivities/Allergies
- ❒ Frequent Colds/Infections
- ❒ Check here if none of above

**Psychological**
- ❒ Depression
- ❒ Irritable/Mood Swings
- ❒ Memory Loss
- ❒ Anxiety
- ❒ Foggy Thinking
- ❒ Stress
- ❒ Check here if none of above.

**Women**
Pregnant? ❒ Yes ❒ No
- ❒ Hot Flashes
- ❒ Breast Lump(s)
- ❒ Check here if none of above

| | | | |
|---|---|---|---|
| ❒ Difficulty Swallowing<br>❒ Seasonal Allergies<br>❒ Check here if none of above. | ❒ Check here if none of above. | ❒ Breast Changes<br>❒ Hair Changes<br>❒ Excessive Thirst<br>❒ Check here if none of above | |

Please indicate whether you have any of these **symptoms**: