COLORADO WEST GENERAL SURGERY

100 Tessitore Ct. Suite B | Montrose, CO 81401 | 970-787-4710

****Please print****

Confidential Record: Information contained herein will not be released except when you have authorized us to do so.

Patient Medical History Form **Referring Doctor** _____ Date _____

Name _____ Male/Female DOB _____

Reason For Visit _____

When did problem first appear? _____ Please list name and approximate date of previous treatment for this problem from other practitioners _____

_____

Ear Nose and Throat Questions Please Check all that apply to **the patient**

- ❑ Sore spot or abnormal bump in mouth or throat
- ❑ Dentures
- ❑ Difficulty Swallowing
- ❑ Sensation of a lump in your throat
- ❑ Hoarseness
- ❑ Pain on swallowing
- ❑ Nosebleeds
- ❑ Obstructed breathing through nose
- ❑ Draining Sinus
- ❑ Headaches
- ❑ Mouth or Throat bleeding
- ❑ Recurrent Sinusitis
- ❑ Hay Fever
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Ear Pain
- ❑ Ear Drainage
- ❑ Dizziness
- ❑ Eye Pain
- ❑ Blind Spots
- ❑ Glaucoma
- ❑ Double Vision
- ❑ Wear hearing aids
- ❑ Wear glasses
- ❑ Wear contacts

Comments: _____

General Health Questions Please Check all that apply to **the patient**

- ❑ Wheezing
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Constant cough
- ❑ Low blood pressure
- ❑ Chest pains
- ❑ Irregular heart beat/Palpitations
- ❑ Urinary infections
- ❑ Heart burn/Acid Reflux (requiring frequent antacids)
- ❑ Colitis
- ❑ Chronic diarrhea
- ❑ Jaundice
- ❑ Pancreatitis
- ❑ Hiatal hernia
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Trouble opening mouth
- ❑ Limited joint motion
- ❑ Muscle weakness
- ❑ Have you ever had any Neurological problem?
- ❑ Head injury
- ❑ Numbness/Weakness
- ❑ Depression
- ❑ Anxiety Disorder
- ❑ Other Mental Problems
- ❑ Anemia
- ❑ Sickle cell disease/trait
- ❑ Easily bruised
- ❑ Fibromyalgia

Comments: _____

Please circle Drug Allergies and give symptoms of reaction ***Penicillin*_____ ***Sulfa*_____**

Codeine*_____ *Latex*_____ *Iodine*_____ *None Known

***Other (please list)* _____**

Children (18 and under)

Immunizations current & up to date? _____ Yes _____ No History of chicken pox? _____ Yes _____ No

Chicken pox vaccine? _____ Yes _____ No

Family History Has a blood relative had:

- ❑ Reaction to anesthesia
- ❑ Bleeding problems
- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer

Medical Illnesses Please Check all that apply to **the patient**

- ❑ Cancer - what part of the body? _____approximate date of diagnosis? _____
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Emphysema or COPD
- ❑ Diabetes
- ❑ Heart troubles
  - ❑ Heart Attack
  - ❑ Rheumatic Fever
  - ❑ Congestive Heart Failure
  - ❑ Atrial Fibrillation
- ❑ High Blood pressure
- ❑ High cholesterol/triglycerides
- ❑ Stroke
- ❑ Epilepsy/Seizures
- ❑ Ulcers
- ❑ Thyroid disorder _____
  - ❑ Hyperthyroid
  - ❑ Hypothyroid
- ❑ Bleeding problems
- ❑ Kidney Stones
- ❑ Hepatitis – Type _____
  - ❑ Active
  - ❑ Inactive
- ❑ HIV/AIDS
- ❑ Obstructive Sleep Apnea
- ❑ Rheumatoid arthritis
- ❑ Pulmonary Embolus
- ❑ History of Recurrent Leg Blood Clots
- ❑ Neurologic Disorders
  - ❑ Multiple Sclerosis
  - ❑ ALS
  - ❑ Other _____

Surgeries/Hospitalizations:

Please list the name and approximate date of **ALL** previous surgical procedures and serious hospitalizations.(not just ENT related)

Name of Operation	Date	Name of Operation	Date

Has **the patient** ever had a serious reaction to anesthesia? ☐ Yes ☐ No If yes, describe _____

Are You Pregnant? ☐ Yes ☐ No ☐ N/A

Has **the patient** ever had a blood transfusion? ☐ Yes ☐ No When? _____

Social History for the patient

Marital Status ☐ S ☐ M ☐ D ☐ W Do you have children ☐ Yes ☐ No _____

Do you have Pets? ☐ Yes ☐ No If yes, what kind_____

Profession_____

Place an "X" in proper Column

	Yes	No		
Do you or have you chewed tobacco?			How long?	Date quit -
Do you or have you ever smoked cigarettes?			How long? How many packs a day?	Date quit -
Do you or have you ever smoked marijuana?			How long? How often?	Date quit -
Do you drink alcohol?			How much per week?	
Do you or have you ever used cocaine or IV drugs?			How often	

Please list ALL medications you are now taking (or attach list if extensive) Please write none if you are not taking any medications

Name	Strength(mg)	Times per day	Name	Strength(mg)	Times per day

Please list your pharmacy of choice for prescriptions. _____