

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                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes/Ears/Throat _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs _____                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart _____                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers _____                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel/Intestinal _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice/Cirrhosis/Liver Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/Bladder _____                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid _____                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures/-strokes _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric, i.e. depression _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss/gain _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol (drinks per week) _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco (packs per day) _____ #years _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Recreational drug use _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is it possible that you are pregnant? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV _____                                     |

Prior surgeries (including minor procedures):  
\_\_\_\_\_  
Date: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_

Problems with anesthesia (describe): \_\_\_\_\_  
\_\_\_\_\_

