9218 Kimmer drive, Suite 107 Lone Tree, CO 80124 Phone (303) 471-4690 Fax (303) 471-4697

New Patient Medical History - Please complete this form prior to your first appointment

Legal Name: _____ Prefer to be called: _____
Date of Birth: ___/___/ ___ Age: ____ Gender: ____ SSN:___- ____- _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Employed: _____ Unemployed: _____ Student: _____ Retired: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our practice?

♦ Insurance Information ♦

What type of claim is this? ___Health Insurance ___ Work Comp ____Auto ____ Self-Pay
Primary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: _____/_____/_____
SSN:___- ____- _____ Policy Holder's Empolyer: _____
Member ID or Claim #:_____ Group #: _____
Effective Date or Date of Injury: _____/_____/_____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Secondary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: _____/_____/_____
SSN:___- ____- _____ Policy Holder's Empolyer: _____
Member ID or Claim #:_____ Group #: _____
Effective Date or Date of Injury: _____/_____/_____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Signature: _____ Date _____/_____/_____

Guarantor (Person responsible to pay the bill):
- Self
- Other: _____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Primary Care, Pain physician, Orthopedics, Psychiatry, etc)

Name of Provider: _____ Office Name: _____ Office #:_____
Name of Provider: _____ Office Name: _____ Office #:_____

♦ Referring Physician ♦

List below who referred you to our practice

Name of Provider: _____ Office Name: _____ Office #:_____

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ Depression or Anxiety			
❑ Anticoagulation			
❑ Neck/ Low Back Pain (Please circle)			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Race:	Religion:	
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Headaches
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Neck Pain
Sore throat	Chest pain	Abdominal pain	Easy bruising	Back Pain
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Weakness
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

- ❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦ *Please list below the most recent dates of your vaccines and health screening tests*					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ **DATE:** _____/_____/_____