NORTHERN COLORADO PLASTIC & HAND SURGERY, PC

NAME: ______________________________________

REASON FOR VISIT:__________________________

____

Sex: M F **Birthdate:**_____________ **Age:**____
Marital Status:____ **Height:**_____ **Weight:**______
Occupation:___________________________________

DATE OF INJURY (if applicable) ________________
Type of accident: Auto___ Work____ Other____
Injured Hand (if applicable): Right Left
Dominant Hand: Right Left

FAMILY HISTORY: Please check Yes if a family member has been known to have the following:

	Yes	Family member
Breast Cancer		
Ovarian Cancer		
Skin Cancer or Melanoma		
Blood Clots/Clotting disorder		
Diabetes		
Heart disease		
High Blood Pressure		
Anesthesia Complications		

PERSONAL HISTORY ***Check item and circle the applicable condition that applies now or in the past.***

__Corrected vision (glasses, contacts, surgery)
__Eye problems (dry eyes, excessive tears, glaucoma)
__Migraine headaches
__Sinus problems / Nasal obstruction
__Hearing loss / Hearing aid / Ringing in ears
__Goiter or Thyroid disease
__Chronic cough / Emphysema / Bronchitis / COPD
__Asthma
__Tuberculosis
__Rheumatic fever
__Heart murmur / Irregular heart beat / Palpitations
__Heart attack / Chest pain
__High blood pressure
__Peptic ulcer / Frequent indigestion or heartburn
__Persistent nausea / Diarrhea / Hernia
__Diabetes / Blood Sugar problems
__Hepatitis / Liver disease
__Bladder / Kidney problems
__Cancer: Type_______________________________
__Radiation / chemotherapy
__Arthritis / Joint disease
__Stroke / Seizures / Fainting episodes
__Back / Neck problems
__Blood clots / Clotting disorders / Abnormal bleeding
__ Bruise easily or extensively
__Anemia
__AIDS / HIV
__Immune system diseases
__Pregnant now, could you be? ________
____# previous pregnancies
____# live births
____# miscarriages/abortions
__Complications from local or general anesthesia
__Alcohol use: ______drinks per week
__Caffeine use: _____cups/cans per day
__Tobacco use: Type? ____________ ______ per day
__Use of Marijuana, cocaine, heroin, methamphetamine
__Use of other street drugs or similar substances
__Premedicate with antibiotics before dental procedures?

APPOINTMENT DATE:_________________________

REFERRED BY:_________________________________
Is this a Doctor or other Healthcare Professional?_____
City or town:___________________________________

FAMILY PHYSICIAN:____________________________
City or town:___________________________________

OTHER PHYSICIANS CURRENTLY TREATING YOU:
City or town and for what condition?
____
____
____

Allergies to Medication/Your Reaction:
____
____

Allergies to other substances/Your Reaction:
____
____

Medications you currently take: (or please give us a list)
____
____
____
____

Vitamins/Supplements you currently take: ________
____
____

Operations you have had: _____________________
____
____
____
____

**I certify that I have read and understand these questions. I will not hold my surgeon or staff responsible for any errors or omissions that I may have made in completing this form.

Signature:______________________________________

Date:___________________
PLEASE USE BACK OF THIS PAGE TO DOCUMENT MORE INFORMATION AND ATTACH ANY LISTS OR, RECORDS YOU WISH US TO HAVE FOR YOUR FILE.

BELOW IS FOR OFFICE USE ONLY************

BMI:__________

DVT Risk Score:________