HEALTH HISTORY

Today's Date: ______________________________

Patient Name:____

Date of Birth:_____________________Height:______________________Weight:________________________

Past Surgeries: Please include all procedures (if additional space is needed use back of page)

Date	Type of Surgery	Where Performed	Complications
1.			
2.			
3.			
4.			
5.			
6.			

Past Medical Problems Please check if you have ever been diagnosed with :

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clot (Leg/Lungs)
- ☐ Breast Cysts/Lumps
- ☐ Cancer
  - Where?___________________
  - Radiation/Chemo__________
- ☐ Chronic Bronchitis
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ Hiatal Hernia/GERD
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Other Anemia
- ☐ Other Liver Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Skin Disease/Rash
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other ___________________

Medical History

Have you had X-rays, Ultrasound's, or MRI's related to today's visit?___________________________
If yes, where?____
Have you ever had a **colonoscopy**?__________________________
If yes, please list date and the results:____

Family History Please list if a family member was ever diagnosed with & their relationship to you :

- ☐ Birth Defects ________________________
- ☐ Bleeding Problems________________________
- ☐ Blood Clot (Leg/Lungs) ____________________
- ☐ Breast Disease____________________________
- ☐ Cancer___________________________________
- ☐ Diabetes_________________________________
- ☐ Heart Attack______________________________
- ☐ Heart Disease_____________________________
- ☐ High Blood Pressure_______________________
- ☐ High Cholesterol__________________________
- ☐ Kidney Disease____________________________
- ☐ Liver Disease_____________________________
- ☐ Problems with Anesthesia__________________
- ☐ Stroke___________________________________
- ☐ Thyroid Disease___________________________
- ☐ Tuberculosis______________________________

Review of Systems Please check all that apply:

General:	☐ Poor Appetite	☐ Weight Loss	☐ Weight Gain	☐ Fatigue
Skin:	☐ Rash	☐ Mole	☐ Non Healing Ulcers	
Neck:	☐ Neck Pain	☐ Mass	☐ Swollen Glands	
Eyes:	☐ Blurry Vision	☐ Double Vision	☐ Contact Lenses/Glasses	
Lungs:	☐ Wheezing	☐ Chronic Cough		
Throat:	☐ Chronic sore throat	☐ Hoarseness	☐ Snoring	
Mouth:	☐ Loose/False/Capped Teeth		☐ Dental Problems	
Heart:	☐ Chest Pain	☐ Swollen ankles/hands		
Abdomen:	☐ Nausea/Vomiting/Diarrhea	☐ Constipation	☐ Blood in stool	☐ Abdomen Pain
Urinary:	☐ Blood in Urine	☐ Nighttime/Frequent Urination	☐ Pain/Burning with urination	

GYN: Last menstrual period:______________________________ ☐Menstrual cycle irregularity
Last mammogram date:________________________ Results:______________________________
Last PAP smear date: __________________________ Results:______________________________
Number of children:___________________________ Number of Pregnancies:______________

Muscle:	☐ Joint Pain	☐ Back Pain	
Neuro:	☐ Headaches	☐ Dizziness	☐ Seizure
Psychiatric:	☐ Anxiety	☐ Depression	☐ Panic Attacks
Endocrine:	☐ Thyroid nodule		
Heme:	☐ Easy Bruising	☐ Easy bleeding	

Social History

What is your occupation?____
Do you smoke?____________If yes, how much per day_____________________How many years?________
Have you ever smoked?_________________If yes, at what age did you quit?__________________________
Do you drink alcohol?__________________If yes, how much?_______________How often?______________
Do you/have you ever taken recreational drugs?____
If *currently* taking, please list:____

Allergies (if additional space is needed use back of page)

Drug Name Reaction
1.____
2.____
3.____

Are you allergic to any contact such as Latex or adhesive tape? ____________________________________
If yes, please list the contact and the reaction you had:____
Are you allergic to any foods?____
If yes, please list the food and the reaction you had:____
Do you have a pace maker?____

Medication/Over the Counter/Supplements (if additional space is needed use back of page)

List ALL medications or supplements and how much you take
1.____
2.____
3.____
4.____
5.____
6.____

Do you take or have you taken Steroids, Coumadin or Plavix?_____________________________________

MEDICATION History Authorization: by signing you give FRONT RANGE SURGICAL SERVICES authorization to request your medication history from your pharmacy and gives us permission to E-Prescribe your prescriptions online.**

***Patient's Signature:**____**Date:**_______________________*

PATIENT INFORMATION SHEET

First Name: ______________________MI: _____Last Name: _______________________________ DOB: __/___/____
Address:____Apt #:______City:__________ State:____Zip:________
Home Phone: (_____)_________-___________ Cell Phone: (______) ___________-____________ ☐Male ☐Female
Email Address:____☐Single ☐Married ☐Divorced ☐Widowed

Primary Care Doctor:______________________________Referring Doctor:_____________________________________
Pharmacy Name:__________________________________Pharmacy Phone #: __________________________________
(list cross streets if # unknown)

Insurance Information
Primary Insurance Name:____Effective Date:_______________
ID or Policy #:_________________________________Group #:___________________________Co-Pay: $___________
Policyholders Name:_______________________________Relation to Patient:_________________DOB:__________

Secondary Insurance Name:____Effective Date:_______________
ID or Policy #:_________________________________Group #:___________________________Co-Pay: $___________
Policyholders Name:_______________________________Relation to Patient:________________DOB:__________

Guarantor (Responsible Party if Patient is under age 18)
First Name: _______________Last Name: _________________Phone: (___)____-_____Relation to Patient:_______
Address:____City:____________State:____Zip:__________

Emergency Contact
Name:____Relationship:__________________Phone #: (____)______-______

***Race*: ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian ☐White**
***Ethnicity*: ☐Hispanic or Latino ☐Non Hispanic or Latino *Language*: ☐English ☐Spanish ☐Other:______**

Financial Agreement and Assignment of Benefits
I understand that I am financially responsible and agree to pay all of FRONT RANGE SURGICAL SERVICES' charges and any related charges that are not paid by insurance or any other third party payer. I authorize payment directly to FRONT RANGE SURGICAL SERVICES for all benefits otherwise payable to me. I UNDERSTAND THAT IF I DO NOT PROVIDE ALL OF THE REQUESTED AND NECESSARY INFORMATION, I WILL BE BILLED DIRECTLY FOR ALL CHARGES UNTIL SUCH INFORMATION IS PROVIDED. I understand that failure to pay outstanding charges on my account may result in escalated collection efforts by an outside collection agency for which I will be responsible for all collection/attorney fees.
Consents and Disclosures
I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general and special instructions of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at FRONT RANGE SURGICAL SERVICES. I understand FRONT RANGE SURGICAL SERVICES encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care.
Cancellation and No Show Policy
If an office visit or office procedure is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance. Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 5 business days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance.
Communication Policy
FRONT RANGE SURGICAL SERVICES will NOT leave messages regarding your medical condition with anyone except the patient or legal guardian UNLESS we have your written permission to do so.
I give FRONT RANGE SURGICAL SERVICES my permission to leave a phone message regarding my medical care with the following:

My home phone/answering machine____________________________________ ______Initials
My cell/voice mail ____ ______Initials
Work/voice mail ____ ______Initials
Significant other (Name) ____ ______Initials

By signing below I certify that I have read this agreement and/or that it has been fully explained to me, that I understand its contents and that I am the patient, or a person duly authorized to execute this agreement, and accept its terms. I fully understand that this consent will remain in effect unless revoked in writing.

Print
Name:____________________________________Sign:__________________________________Date:__________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices from Front Range Surgical Services, P.C.

____
Print Name

______________________________ ____________
Patient Signature (or Patient Representative*) Date

____

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ______________________________

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.