ORTHOPAEDIC & SPINE CENTER
OF THE ROCKIES

MRN: _____

Name: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female**

Age: _____ **Height:** _____ **Weight:** _____ **BMI:** _____ ***(OFFICE USE ONLY)***

Current Medications & Supplements

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies **Reaction**

_____

_____

_____

_____

_____

_____

All Previous Surgeries **Date**

_____

_____

_____

_____

_____

Medical History: ***Please check the box(s) if you have ever been diagnosed with the following***

Heart

☐ Heart Attack / MI: _____ (Year)
☐ High blood pressure
☐ Irregular Heartbeat (A-Fib)
☐ Heart failure/CHF ☐ Pacemaker
☐ Valve replaced ☐ Defibrillator
☐ Heart Surgery: _____ (Year)
☐ Cath ☐ Bypass ☐ Stent

Lungs

☐ Emphysema/COPD: ☐ On Oxygen Liters ___
☐ Asthma:
☐ Sleep Apnea ☐ Use CPAP
☐ Chronic Bronchitis
☐ Tuberculosis (TB)
☐ Recent Pneumonia:
☐ Other: _____

Brain

☐ Stroke ☐ TIA
☐ Seizures (in past 5 years)
☐ Depression/Anxiety ☐ Bipolar
☐ Alzheimers/Dementia
☐ Parkinsons
☐ Glaucoma
☐ Other: _____

Endocrine/Kidney

☐ Diabetes ☐ On Insulin
☐ Thyroid Disease
☐ Liver Disease / Cirrhosis
☐ Kidney Failure ☐ On Dialysis
☐ Other: _____

Blood/Cancer

☐ Blood Clots (DVT in legs, PE)
☐ On a Blood Thinner: _____
☐ Anemia
☐ Cancer: _____ (type)
☐ Other: _____

GI System

☐ GI Bleed
☐ Ulcer
☐ Acid Reflux / Heartburn
☐ Hiatal Hernia
☐ Other: _____

Infections

☐ HIV / AIDS
☐ Hepatitis B / C
☐ MRSA
☐ Current Active Infection
☐ Other: _____

Rheumatology

☐ Rheumatoid Arthritis (RA)
☐ Lupus (SLE)
☐ Fibromyalgia
☐ Other: _____

Social History

☐ Smoke: _____ packs/day
☐ Chew Tobacco
☐ Alcohol use: _____ drinks/day
☐ Use Street Drugs/Marijuana
☐ Withdrawal from alcohol/drugs

Additional Medical Information: _____

_____

PATIENT HEALTH HISTORY

Patient Sticker

OFFICE USE ONLY

BMI: _____ **≥ 45 = ANESTHESIA CONSULT**

Name: _____ **Age:** _____ **Date of Birth:** _____

Last Menstrual Period: _____ **Are You Pregnant?** _____

REVIEW OF SYSTEMS

Please check box(s) if you have experienced the following within the past 6 months

General
- ☐ Poor Appetite
- ☐ Unexplained weightloss
- ☐ Recent Fever

Head
- ☐ Frequent Headaches

Eyes
- ☐ Visual Changes

Throat
- ☐ Chronic Sore Throat
- ☐ Difficulty Swallowing

Mouth
- ☐ Recent Dental Infection

Lungs
- ☐ Shortness of Breath
- ☐ Chronic Cough

Heart
- ☐ Chest Pain
- ☐ Pounding of Heart
- ☐ Chronic Leg Swelling

Abdomen
- ☐ Nausea/Vomiting
- ☐ Bowel Irregularities
- ☐ Blood in Stools
- ☐ Recurrent Indigestion
- ☐ Abdominal Pain

Urinary
- ☐ Urinating at Night
- ☐ Frequent Urination
- ☐ Painful/Burning Urination

Blood
- ☐ Bruise Easily
- ☐ Bleed Easily

Skin
- ☐ Infection
- ☐ Ulcer/Wound

Other
_____
_____
_____
_____

Anesthesia History:

- ☐ Life threatening/Severe reaction to Anesthesia
  Explain: _____
- ☐ History of Difficult Intubation (breathing tube)
  Explain: _____
- ☐ History of Malignant Hyperthermia: ☐ Self ☐ Family
  Explain: _____
- ☐ Significant Nausea or Vomiting after Anesthesia
- ☐ Severe Motion Sickness
- ☐ Dental: Loose or Capped Teeth

Allergies:

- ☐ Allergy to certain Anesthetics (gas, IV, Local ie: "caines")
  Explain: _____
- ☐ Allergy to Latex: Reaction: ☐ Swelling/Breathing ☐ Rash
- ☐ Allergy to Adhesives/ Tape: Reaction: _____
- ☐ Allergy to Food(s): List: _____
  _____
- ☐ Eggs: Reaction: _____

Other:

- ☐ History of Chronic Pain/Daily Narcotics
- ☐ Contact Lenses ☐ Hearing Aids ☐ Piercings
- ☐ Implanted Hardware/Metal or Devices: Explain: _____
  _____
- ☐ Cortisone (steroid) use in last year: ☐ Pills ☐ Injection
- ☐ History of a Blood Transfusion: Reaction: ☐ Yes ☐ No
  Explain: _____

Family History:

- ☐ Blood Clots
- ☐ Heart Attack/Disease
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Bleeding Disorders
- ☐ Liver Disease
- ☐ Kidney Disease

Date: _____ Patient Signature: _____ MA Signature: _____

Updated: _____ Patient Signature: _____ MA Signature: _____

PATIENT HEALTH HISTORY

Patient Sticker