Anderson Medical Center
4743 Arapahoe Avenue, Suite 102
Boulder, CO 80303

Avista Medical Office Building
80 Health Park Drive, Suite 250
Louisville, CO 80027

www.alpinesurgical.net
Phone 303.449.3642 Fax 303.440.7298

PERSONAL INFORMATION: **Today's Date: _______________**

NAME: Last, First, MI: ______________________________ ☐ Male ☐ Female ☐ Other

Mailing/Billing Address: ______________ City: ______________ State: ______ Zip: __________

Physical Address: ______________ City: ______________ State: ______ Zip: __________

Home Phone Number: ______________________ Cell Phone Number: ______________________

Work Phone Number: ______________________ Email Address: ______________________

The office may leave detailed messages on my: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Date of Birth: ____/___/______ Age: __________ Social Security Number: _____ /____/_____

Height: __________ Weight: ___________ Blood Pressure (if known): ____________

Employer: ______________________________ Occupation: ______________________________

Employer Address: ______________ City: ______________ State: ______ Zip: __________

Marital status O Single O Significant Other O Married O Legally Separated O Divorced O Widowed

Spouse's/Other's Name: ______________________________ Work/Cell Phone Number: __________________

SOCIAL HISTORY:

Alcohol O Yes O No How Often ____

Smoking O Yes O No How Many Per Day/Week ______________________________________

Recreational drugs O Yes O No Explain What and How Often ______________________________

Primary Care Physician: ______________________________ Phone Number: ______________________

Whom may we thank for referring you to us: ______________________ ☐ Friend ☐ Doctor ☐ Other

What pharmacy do you currently use? Pharmacy location and phone: ______________________________

EMERGENCY CONTACT:

Name: ______________________________ Relationship: ______________________________

Address: ______________________________ Home Phone: ______________________________

City: ___________________ State: _____ Zip: ________ Work Phone: ______________________________

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This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released to any person except when you have authorized us to do so.

REASONS FOR THE OFFICE VISIT TODAY (Please list primary symptoms/concerns):

1. ____Right/Left

2. ____Right/Left

MEDICATIONS: List any medications you are currently taking (including herbals and supplements).

Check here if NONE ☐

Medication	Frequency	Medication	Frequency

PERSONAL MEDICAL HISTORY (PLEASE COMPLETELY FILL IN BUBBLES THAT APPLY TO YOUR HISTORY)

Diabetes O Yes
HyperThyroidism O Yes
HypoThyroidism O Yes
HyperParathyroidism O Yes
Elevated Cholesterol O Yes
Heart Attack O Yes
Heart Arrhythmia O Yes
Heart Failure O Yes
Stroke/TIA O Yes
Blood Clot O Yes
Pulmonary Embolism O Yes
Anemia O Yes
High Blood Pressure O Yes
Peptic Ulcer Disease O Yes

GERD O Yes
Colitis O Yes
Diverticular Disease O Yes
Kidney Stones O Yes
Kidney Failure O Yes
Seizures O Yes
Asthma O Yes
COPD/Emphysema O Yes
Sleep Apnea O Yes
HIV/AIDS O Yes
Cancer O Yes
Type of Cancer________________________________

Check here if NONE of these apply ☐

Other Medical History:____

____

ALLERGIES: Please specify if you are allergic to any medicines or medical supplies (including iodine, tape, latex, and shellfish). **Check here if NONE** ☐

ALLERGY and REACTION (example: Latex-Rash)