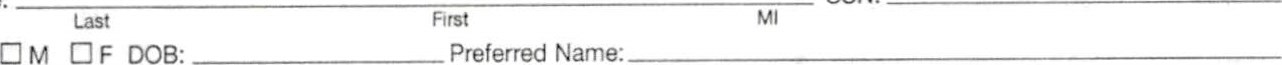
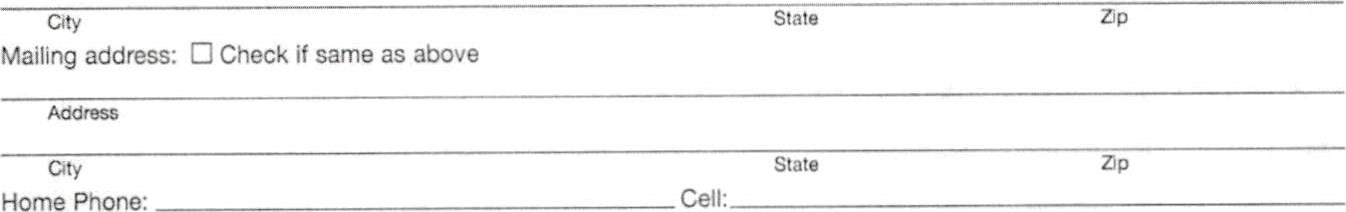
Complete New Patient Paperwork Online! Visit epic.mycenturahealth.org to complete your Health History Questionnaire and update your information.

PATIENT INFORMATION

Name: SSN:

Sex: 

Address:



Email:

Marital Status(Circle): Divorced Legally Separated Married Significant Other Single Widowed Declined

Would you prefer to speak to your healthcare provider through a translator? Yes No

Preferred Language: English Other (please specify): Written Language:

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or circle to Decline Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Ethnicity: Do you consider yourself to be Hispanic or Latino? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Declined

Race circle: American Indian or Alaska Native Native Hawaiian or other Pacific Islander White

Black or African American Asian Declined  
 Employer: Employer Phone: Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status: \_\_ Part-time \_\_\_ Full-time \_\_\_ Self-Employed \_\_\_Retired \_\_\_Active Military \_\_\_\_ Disabled \_\_\_Unemployed

PHARMACY Address/Cross Streets Phone Number Preferred



Alternative: Mail Order:

# CARE TEAM

Primary Care Provider. Phone Number:

Specialist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_   
Specialist Name: Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

Name: LAST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: LAST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTY RESPONSIBLE FOR PAYMENT Check if same as patient \_\_\_\_\_

Name: LAST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: Relation to patient: Employer:

Advance Directives:

Do you have a Living Will / DNR? \_\_\_\_\_ Yes \_\_\_\_\_ No Do you have a Durable Power of Attorney? \_\_ Yes \_\_No

If yes:

Please Print Name Phone Number Would you like information regarding Advance Directive? \_\_\_Yes \_\_No

Chief Complaint (Reason for Visit):

ALLERGIES: \_\_\_\_ No Known Drug Allergies

Medication: Reaction:

Medication: Reaction: Medication: Reaction:

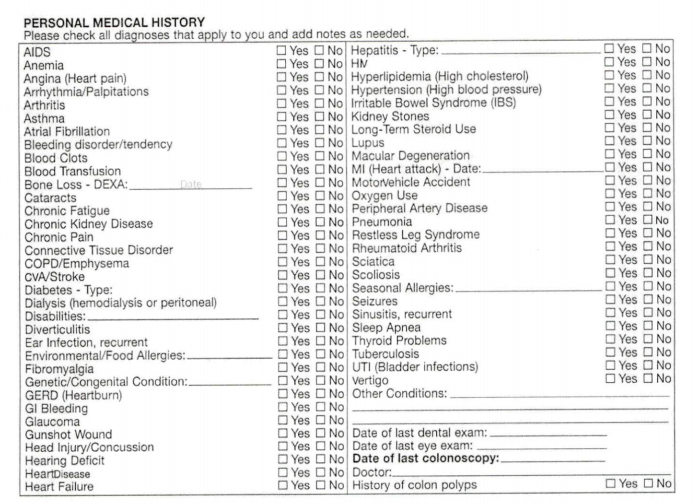
Other (latex, adhesive, food, environment): Other (latex, adhesive, food, environment):  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS: \_\_\_ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dose | How often do you take | Reason for taking medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

PATIENT INFORMATION:   
Name: LAST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Name: LAST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

|  |  |  |  |
| --- | --- | --- | --- |
| Year | Surgery/Procedure | Hospital/Location | Complications/Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever had a reaction to general anesthesia? \_\_\_ Yes \_\_\_\_ No

Additional Personal Medical History

|  |  |  |
| --- | --- | --- |
| FEMALE PATIENTS ONLY  C) Abnormal Pap smear  C] Other GYN history (indicate below)  Age of first menstrual period:  Date of last menstrual period:  Age of menopause: | Form Of contraception (if any):  Last mammogram:  Last Pap smear:  Currently pregnant? D Yes C] No  Currently breastfeeding? C] Yes C] No | Planning pregnancy? Yes No  Number of Pregnancies:  Number of Deliveries:  Number of Elective abortions:  Number of Miscarriages: |

SOCIAL HISTORY

Tobacco: \_\_None Quit Date:

\_\_ Pipe/Cigar \_\_\_ Cigarettes Packs/Day: \_\_\_\_\_\_\_\_\_\_ Number of years smoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Smokeless tobacco \_\_\_\_ Electronic or E-Cigarette Secondhand smoke exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: \_\_\_ None \_\_\_ Daily \_\_\_\_Occasional \_\_\_\_\_ Trying to cut down \_\_\_\_ In recovery  
Amount per week: \_\_\_\_\_\_\_\_\_\_

Drug Use:  None  Past Use  Current  
How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?  
 None  One or more  Marijuana  Amphetamines  Cocaine  Designer/Club

Route:  Smoke  Inject  Ingest  Topical

Sexual Activity:  Not active  Active Number of lifetime sexual partners: \_\_\_\_\_\_\_\_\_\_  Men  Women  Both Do you have a caregiver? Yes  No

Name: Relationship:

Diet:  Well Balanced  Diabetic  Vegetarian  Fast food/Fats/Carbs  Vitamins/Herbs  Weight Loss Products:

Exercise/Activity Level:  Sedentary  Strength/Wt. Training  Stretch/Balance

* Twenty minutes/day exercise  Exercise three times weekly  Aerobic/Cardiac

With whom do you live?  Alone  Children  Spouse/Partner  Parents  Assisted Living:

Education:  GED  High School  Did not complete High School  College  Advanced Degree  Technical/ Trade

Occupation:

Leisure activities**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Religion:

Do you:  Use seatbelts  Use a helmet  Have guns in home  Have smoke detector in home

Abuse:

I feel safe at home:  Yes  No

Is there anyone you are afraid of?  Yes  No

Do you have a history of abuse?  Yes  No

Travel:

In the last 30 days, have you traveled to any foreign countries?  List:

IMMUNIZATIONS

Please provide any known dates or full immunization record(s).

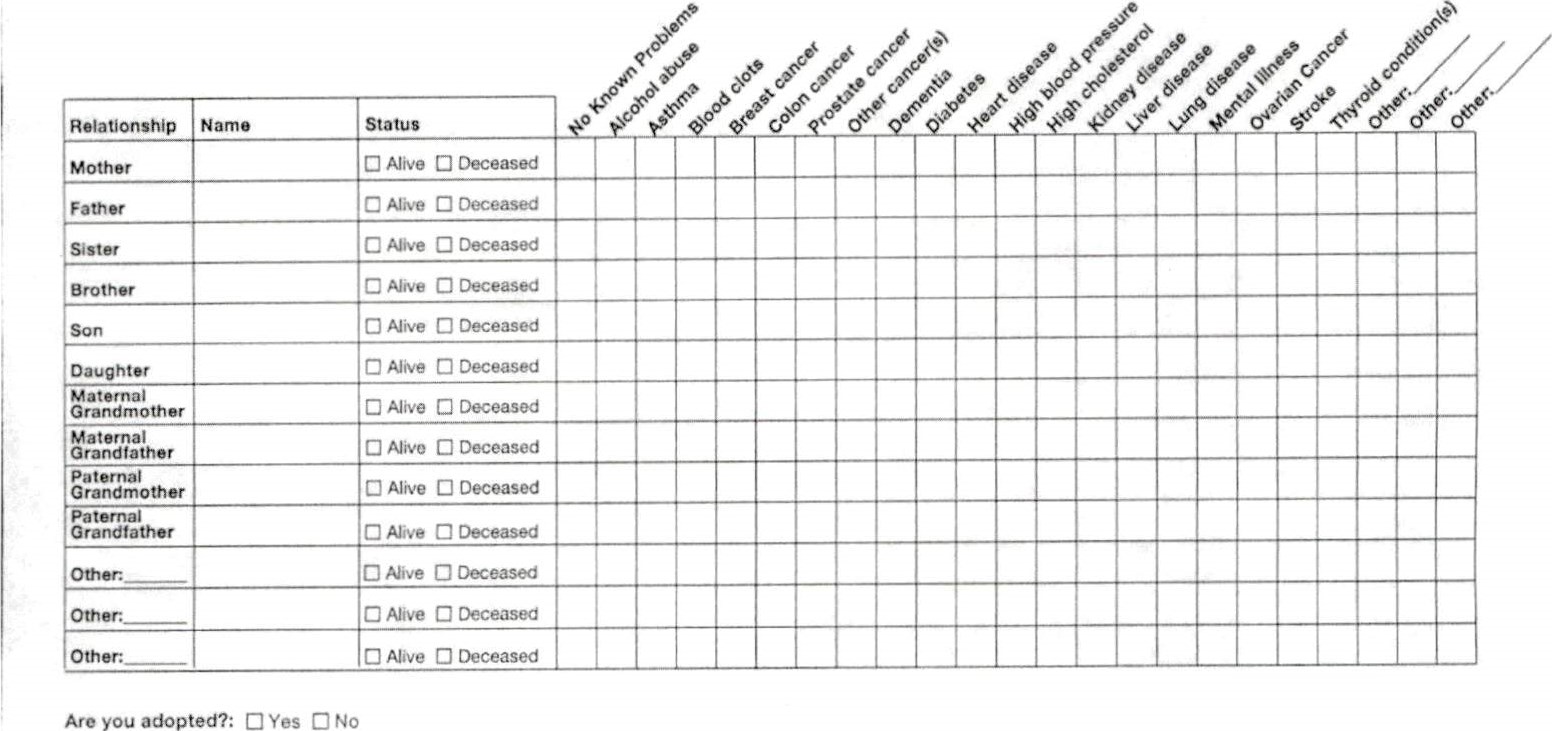
Tetanus or Tetanus/Pertussis: DATE: ­­­­­\_\_\_\_\_\_\_\_\_ Influenza: DATE: \_\_\_\_\_\_\_ Shingles: DATE: \_\_\_\_\_\_\_\_\_\_  
Meningitis: DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A: DATE: \_\_\_\_\_\_\_\_\_\_\_ Hepatitis B: DATE: \_\_\_\_\_\_\_\_\_\_  
HPV: DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumococcal 13 or 23: DATE: \_\_\_\_\_\_\_\_\_\_ / DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_  
OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

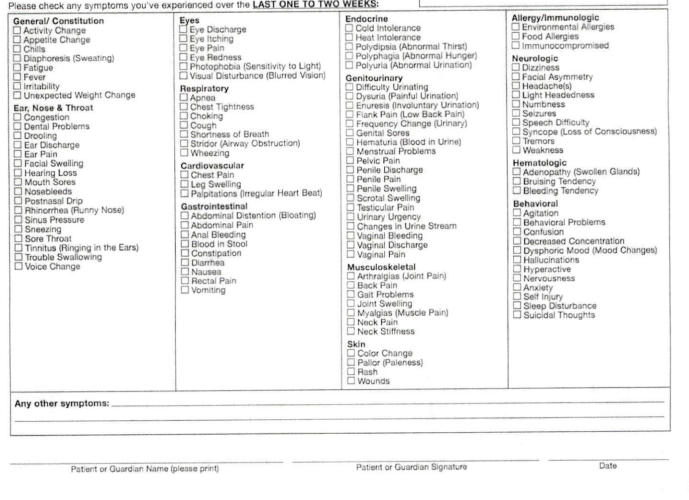
PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION:

Name: LAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FIRST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, it known.





SPINE QUESTIONNAIRE

Colorado Comprehensive Spine Institute

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Phone: If not referred by a doctor, how did you hear about us?

HISTORY OF PRESENT COMPLAINT

Where is your problem located?  Neck  Upper Back Arm  Lower Back  Hip  Leg

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since 

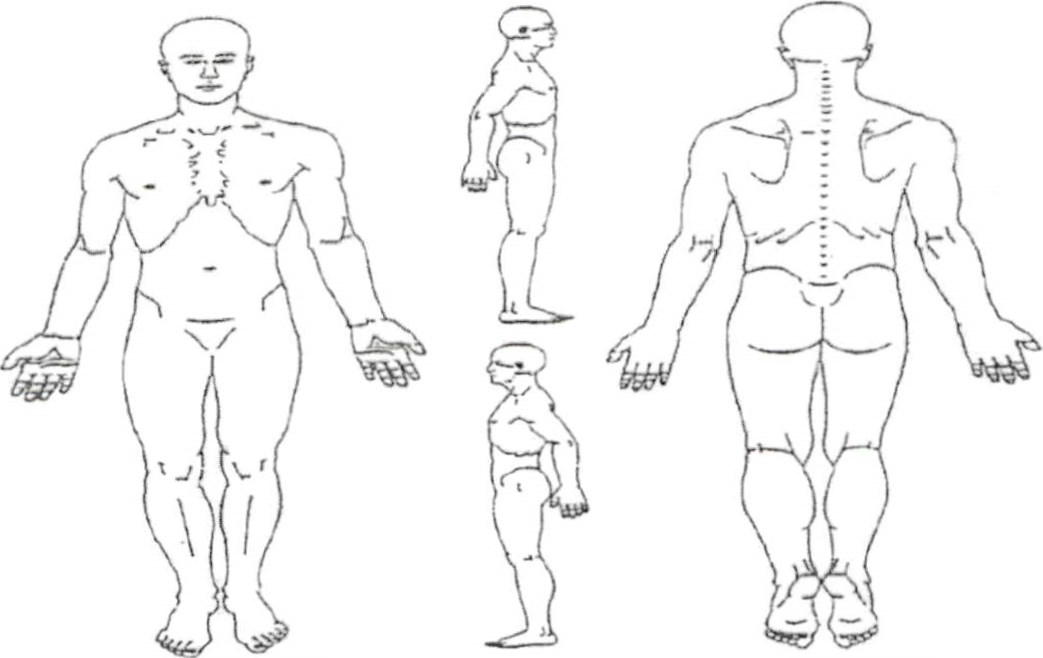
Briefly, please describe the onset of your current back/neck pain and the events preceding your pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was this from a work-related injury?  No  Yes   
Is it under Workers Compensation?  No  Yes

Have you missed any work because of this problem?  No  Yes   
How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Was this from an auto injury?  No  Yes

Please indicate where you have pain by marking the areas on your body where you have the described sensations. Use the appropriate symbol:

ACHE >>>> NUMBNESS ------- PINS & NEEDLES 0000 BURNING XXXX STABBING ////



PAIN SCALE

Colorado Comprehensive Spine Institute

Circle a number to indicate the level of your pain for the current injury in the situations listed below:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PAIN TODAY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GREATEST PAIN | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| PAIN AT REST | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Which of the following activities change the nature of your pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

