UC Health Falcon Medical Center

Phone: 719-364-9555 Fax: 719-364-9565

Last Name	First Name	MI	Birth Date
Address			
Preferred Phone # :	Home	Cell	Work
Email	Occupation		
How did you hear about us?			
Which pharmacy do you prefer to use & location?			
Please list the top 2 reasons for your visit today?			
Ethnicity: (Example: Caucasian, African American, Asian, etc...)			
Race: Hispanic Non-Hispanic Decline to Answer			

TOBACCO HISTORY			
Tobacco use: Yes / No		Types of Tobacco Used:	Cigarettes Pipe Cigars
Quit date:		Packs per day:	How many Years:
Smokeless Tobacco: Yes / No		Types used:	Snuff Chew
Quit date:			
Ready to Quit? Yes / No			

MEDICAL HISTORY (Your personal history) : Please circle all that apply			
Anemia	Diabetes mellitus	Myocardial infarction	
Anxiety	Emphysema	Nerve / muscle disease	
Arthritis	GERD	Osteoporosis	
Asthma	Glaucoma	Seizures	
Blood transfusion	Heart murmur	Sickle cell anemia	
Cancer	HIV / AIDS	Stroke	
Cataracts	Hypertension	Substance abuse	
CHF	Kidney disease	Thyroid disease	
Clotting disorder	Meningitis	Tuberculosis	
COPD		Ulcers	
Depression			

SURGICAL HISTORY Please circle all that apply			
Appendectomy (appendix)	Colon surgery	Joint replacement	
Brain surgery	Cosmetic surgery	Small intestine surgery	Prostate surgery
Breast surgery	Eye surgery	Spine surgery	Vasectomy
C-Section	Fracture surgery	Tonsillectomy	
Heart bypass	Hernia surgery	Tubal Ligation	
Cholecystectomy (gallbladder)	Hysterectomy	Valve replacement	

FAMILY HISTORY:
Please complete if any of your family members (including parents,sibling,children) have/had any of these.

	RELATIONSHIP		RELATIONSHIP
Diabetes		Colon cancer	
High blood pressure		Prostate cancer	
High cholesterol		Asthma	
Early Coronary artery disease		COPD	
Stroke		Depression	
Clotting disorder		Alcohol abuse	
Breast cancer		Alzheimer's disease	
Ovarian cancer		Rheum arthritis	
OTHER:		Autoimmune disease	

SOCIAL HISTORY			
Alcohol Use: Yes / No		Drug use: Yes/No	
# of drinks per week:		Marijuana	
# of glasses of wine:		Methamphetamines	
# of cans of beer:		Cocaine	
# of shots of liquor:		IV	
Sexually Active: Yes / No / Not Currently			
Partner(s): Male / Female			
Type of Birth Control / Protection:			
What gender do you identify as? Male Female Decline to Answer			
What gender was assigned at birth? Male Female Decline to Answer			
What is your current sexual orientation? Straight Homosexual Transgender Bisexual Decline to Answer			
Total # of pregnancies:	Live births:	Abortions:	Miscarriages:

Over the past 2 weeks, how often have you been bothered by any of the following:			
Little interest/pleasure in doing things? Not at all	Several days	More than 1/2 of the days	Nearly daily
Feeling down/depressed/hopeless? Not at all	Several days	More than 1/2 of the days	Nearly daily
HEALTH CARE DIRECTIVE			
Do you have a Healthcare Directive? Yes / No / Unknown			
Please list the type of Healthcare Directive:			
CO CPR Directive/Do not resuscitate			
Living Will			
If applicable, who is your healthcare decision maker for the following:			
Medical Durable Power of Attorney (MDPOA)			
Verbally appointed decision maker			
Healthcare court appointed guardian			
Are you an organ donor? Yes / No			

Place an X next to the symptoms you are CURRENTLY having.

Constitution	EYES	GI	NEUROLOGICAL
Activity change	Eye discharge	Abdominal bloating	Dizziness
Appetite change	Eye itching	Abdominal pain	Facial asymmetry
Chills	Eye pain	Anal bleeding	Headaches
Sweating	Eye redness	Blood in stool	Light-headedness
Fatigue	Light sensitivity	Constipation	Numbness
Fever	Visual disturbance	Diarrhea	Seizures
Unexpected weight change		Nausea	Speech difficulty
HENT	**RESPIRATORY**	Rectal pain	Syncope
Facial swelling	Apnea	Vomiting	Tremors
Neck pain	Chest tightness	**MS**	Weakness
Neck stiffness	Choking	Joint pain	**HEMATOLOGIC**
Ear discharge	Cough	Back pain	Enlarged lymph nodes
Hearing loss	Shortness of breath	Gait problem	Bruises / bleeds easily
Ear pain	Wheezing	Joint swelling	**PSYCHIATRIC**
Ringing in ears		Muscle pain	Agitation
Nosebleeds	**CARDIOVASCULAR**	**SKIN**	Behavior problem
Congestion	Chest pain	Color change	Confusion
Runny nose	Leg swelling	Paleness	Decreased concentration
Postnasal drip	Palpitations	Rash	Depressed
Sneezing		Wound	Hallucinations
Sinus pressure			Hyperactive
Dental problem			Nervous / anxious
Drooling			Self-injury
Mouth sores			Sleep disturbance
Sore throat			Suicidal ideas
Trouble swallowing			
Voice change			

Other:____

Please explain any symptoms you circled above:

Please list any medications you are taking.

INCLUDING prescriptions, over the counter, vitamins, and supplements.

You may also provide us with a copy of your CURRENT medication list if you prefer.

NAME	DOSE	FREQUENCY

DO YOU NEED ANY NEW/REFILLS OF MEDICATION TODAY?

PLEASE LIST ANY ALLERGIES YOU MAY HAVE:

MEDICATION ALLERGIES	REACTION

OTHER ALLERGIES	REACTION

Do you exercise:			
Frequency (How many days per week)			
Length of time per day			
Intensity	Low Moderate High		
What type of exercise ?	Cardio Weight training Yoga Team sports Other		
How many hours per day do you spend sitting?			
Diet			
How many servings of the following do you eat per day?			
	Fruits and Vegetables?		
	Non-fat, low fat dairy foods, or fortified dairy alternatives?		
How often do you eat out ?			
How many sugar-sweetened beverages (12 oz. or more) do you drink per week?			
How many servings of low fat meat or low fat protein do you eat per day?			
Sleep			
How many hours of sleep do you get per night?			
Rate your quality of sleep	Very poor Poor Moderate Good Very Good		
Safety			
Do you sports helmets (skiing, biking) ?			Yes No Sometimes
Do you wear seatbelts?			Yes No Sometimes
Do you talk/text while driving?			Yes No Sometimes
Do you have guns in your home?			Yes No Decline to Answer
Do you use sun protection (hats, sunscreen, protective clothing) ?			Yes No Sometimes
Do you use sun eye protection (sunglasses)?			Yes No Sometimes