

VAIL
 181 West Meadow Drive - Suite 800
 Vail, Colorado 81657-5059
 970-476-7600

Colorado Mountain Medical, PC
Stephen P. Laird, MD, MS
 Gastroenterology and Hepatology

MR# _____

EAGLE
 377 Sylvan Lake Road
 Eagle, CO 81631
 970-328-1650

PATIENT INFORMATION SHEET

NAME _____ SEX: M F DOB: _____ AGE: _____ DATE: _____
 MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ NUMBER OF CHILDREN: _____
 PRIMARY CARE PHYSICIAN _____

It is important for our physicians/PAC to have your complete health history. Please help us by taking the time to provide this information accurately and completely.
 This information will be a confidential part of your medical records.

PAST SURGICAL AND MEDICAL HISTORY - (Circle Yes or No) If yes, date of onset, comments.

MEDICAL HISTORY	YES	NO	Onset, Comments	SURGICAL HISTORY	YES	NO	Date, Comments
Anorexia / Bulimia	YES	NO		Colon	YES	NO	
Arthritis / Joint Swelling	YES	NO		Stomach	YES	NO	
Asthma	YES	NO		Heart:	YES	NO	
Bleeding Disorder	YES	NO		Stent / Bypass	YES	NO	
Blood or Infectious Disease	YES	NO		Valve	YES	NO	
Cancer, Type:	YES	NO		Pacemaker	YES	NO	
Colon polyps	YES	NO		Defibrillator	YES	NO	
Crohn's Disease	YES	NO		Joint Replacement	YES	NO	
Diabetes	YES	NO		Gallbladder	YES	NO	
Epilepsy / Seizures	YES	NO		Hysterectomy	YES	NO	
Gallstones	YES	NO		Appendix	YES	NO	
Glaucoma	YES	NO		Prostate	YES	NO	
Headaches / Fainting / Dizziness	YES	NO		Bladder	YES	NO	
Heart Problems / Chest Pain	YES	NO		C-Section	YES	NO	
Hepatitis / Liver Problems	YES	NO		Breast	YES	NO	
Hiatal Hernia / GERD	YES	NO		Other Surgeries			
High / Low Blood Pressure	YES	NO		Other Surgeries			
Kidney Disease	YES	NO		Other Surgeries			
Lung Disease	YES	NO		Other Surgeries			
Pacemaker / Internal Defibrillator	YES	NO		Anesthesia Problems	YES	NO	
Sleep Apnea	YES	NO		Previous EGD	YES	NO	
Stomach Problems / Ulcers	YES	NO		Previous Colonoscopy	YES	NO	
Stroke	YES	NO		Vaccinations (Yes or No, and date)			
Thyroid Problems	YES	NO		Hepatitis A	YES	NO	
Tuberculosis	YES	NO		Hepatitis B	YES	NO	
Ulcerative Colitis	YES	NO					

Other

Other

Other

CURRENT MEDICATIONS: Please include vitamins, herbs and pain relievers AND RECENT ANTIBIOTICS

Medication	Dosage	Times per Day	Medication	Dosage	Times per Day

ALLERGIES	REACTION	ALLERGIES	REACTION	ALLERGIES	REACTION

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NAME _____ SEX: M F DOB: _____ AGE: _____ DATE: _____

SOCIAL HISTORY: (PAST OR CURRENT)	YES	NO		
Alcohol	YES	NO	Quit	Duration & Amount
Coffee / Caffeine	YES	NO	Quit	Duration & Amount
Substance Abuse	YES	NO	Quit	Duration & Amount
Tobacco	YES	NO	Quit	Duration & Amount
Blood Transfusions	YES	NO	When?	
Tattoos	YES	NO		
Do you exercise	YES	NO	How Much?	

FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.

	YES	NO		
Alcoholism	YES	NO		
Cirrhosis / Jaundice	YES	NO		
Colon Cancer	YES	NO		
Colon or Rectal Polyps	YES	NO		
Crohn's / Ulcerative Colitis	YES	NO		
Diabetes	YES	NO		
Gallstones	YES	NO		
Hemochromatosis	YES	NO		
Heart Disease	YES	NO		
High Blood Pressure	YES	NO		
Liver Disease	YES	NO		

SYMPTOM REVIEW: Check (X) symptoms you currently have or have had in the past

<input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever / Chills <input type="checkbox"/> Poor Vision / Double Vision <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Frequent Nosebleeds <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Swallowing Difficulties <input type="checkbox"/> Pain with Swallowing <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Incontinence of Urine <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Arthritis / Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> New or Chronic Rash <input type="checkbox"/> Nail Changes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures	<input type="checkbox"/> Memory Loss <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Hair Loss <input type="checkbox"/> Hot / Cold Sensitivity <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Swelling of Ankles / Legs
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OTHER

OTHER

Physician notes if needed:

OTHER PHYSICIANS WHO ARE ACTIVELY TREATING YOU:

Doctor: _____ Condition: _____

Doctor: _____ Condition: _____

REVIEWED BY: _____ **DATE:** _____

IF THIS FORM WAS FILLED OUT MORE THAN 30 DAYS AGO, PATIENT AND PHYSICIAN WILL REVIEW AND UPDATE:

Patient Signature: _____ Physician Signature: _____ Date: _____ No Changes Changes Made

Patient Signature: _____ Physician Signature: _____ Date: _____ No Changes Changes Made

Physician / PAC Signature: _____