Surgical History:

Surgery/Procedure: _____ Year: _____
Surgery/Procedure: _____ Year: _____
Surgery/Procedure: _____ Year: _____
Surgery/Procedure: _____ Year: _____

Allergies to Medications: ☐ Yes (detail below) ☐ No Known Drug Allergies

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Medications: *Please list all medications including Over The Counter*.

Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____
Medication: _____ _____mg – times taking a day _____

Preferred Pharmacy (Name/Phone Number): _____

Social History:

Occupation: _____

Education: ☐ GED ☐ High School ☐ College ☐ Advanced Degree ☐ Technical/Trade

Recreation/Hobbies: _____

Usual activities required for work and/or recreation:

☐ sitting ☐ standing ☐ walking ☐ running ☐ jumping ☐ pulling ☐ twisting ☐ stretching ☐ bending ☐ pushing ☐ lifting _____ lbs

Do you have children? ☐ No ☐ Yes How many? _____ Do they live with you? _____

Are you exclusively responsible for anyone else's care? ☐ No ☐ Yes Who? _____

Do you smoke? ☐ No, I have never smoked ☐ No, I quit smoking ____ years ago, I smoked _____ packs per day for _____ years

☐ Yes, I currently smoke cigarettes/cigars/pipe _____ Packs per day for _____ years

Do you drink alcohol? ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut down ☐ In recovery Amount per week: _____

Do you use drugs? ☐ None ☐ Past Use ☐ Current - please list: _____

Last date of your Mammogram: _____ Last date of your Colonoscopy: _____

Last date of your DEXA/Bone Density: _____ Last date of your PAP Smear: _____

Past Medical History/Family Medical History

Please Check any condition you and any immediate blood relative have been treated for:

YOU	Condition	Relative(s): (mother,father,sister,brother,grandparent,children)
☐	**Asthma/COPD/Emphysema**	
☐	**Cancer: _____**	
☐	**Congestive Heart Failure**	
☐	**Depression/Anixety**	
☐	**Heart Attack**	
☐	**Heart Disease/High Blood Pressure**	
☐	**Thyroid Disease**	
☐	**Diabetes**	
☐	**Parkinson's/Alzheimer's**	
☐	**Sleep Disorders**	
☐	**High Cholesterol**	
☐	**Mental Health Disorder**	
☐	**Neurologic Disorder**	

PEAK INTERNAL MEDICINE

400 S. McCasalin Blvd Suite 200
Louisville,CO 80027
Phone: 720-222-0648 Fax: 720-222-0654

Patient Information Intake

Name: Last: _____ First: _____ MI: _____ Nickname: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex: M F

Marital Status: Divorced Married Single Widowed Significant Other

Preferred Language: English Other: _____ Ethnicity: _____

Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____

Please Initial if you give our clinic permission to leave a details message with health information on your voice mail: _____

Home Address: _____ City: _____State: _____ Zip: _____

Email : _____

Emergency Contact: _____ Relation: _____ Phone: _____

Please list any persons you authorize the clinic to leave personal health/medical information with:

Name: _____Phone: _____ Relation: _____

Name: _____Phone: _____ Relation: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____
Policy Holder SS#: _____ Policy Holder SS#: _____

Your Place of Employment:_____

Advanced Directive:

Do you have a Living Will/DNR? Yes No

Do you have a Durable Power of Attorney Directive? Yes No

If yes, please print name: _____ Phone: _____

Signature: _____ Date: _____

Printed Name: (if different from patient) _____ Relation: _____