UNIVERSITY OF COLORADO HOSPITAL

PATIENT INTAKE FORM

Tobacco Use History

Tobacco Use?

Packs/Day (circle one) 0 .5 1 1.5 2 Other

Quit Date: _____

Smokeless Tobacco

Quit Date: _____

Ready to Quit: ☐ Yes ☐ No

Comments: _____

Types of Tobacco Used: (circle all that apply)	Cigarettes	Pipe	Cigar
Years Used	_____	_____	_____
Quit Date	_____	_____	_____
Types (circle one)	Snuff	Chew	
Counseling Given (circle one)	Yes	No	

Surgical History (mark all that apply)

Appendectomy	☐ Yes ☐ No	C-section	☐ Yes ☐ No	Prostate surgery	☐ Yes ☐ No
Brain surgery	☐ Yes ☐ No	Eye surgery	☐ Yes ☐ No	Small intestine surgery	☐ Yes ☐ No
Breast surgery	☐ Yes ☐ No	Cardiac	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
CABG	☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Cholecystectomy	☐ Yes ☐ No
Hysterectomy	☐ Yes ☐ No	Tubal ligation	☐ Yes ☐ No	Colon surgery	☐ Yes ☐ No
Joint replacement	☐ Yes ☐ No	Valve replacement	☐ Yes ☐ No	Cosmetic surgery	☐ Yes ☐ No

Other surgical history: _____

Relationship	Status	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Early death	Hearing loss	Heart disease	High blood pressure	Kidney disease	Learning disabilities	Mendal illness	Mental retardation	Miscarriages	Stroke	Substance abuse	Vision loss			
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							
Mother's sister																							
Mother's brother																							
Father's sister																							
Father's brother																							
Mother's mother																							
Mother's father																							
Father's mother																							
Father's father																							
Other																							
Neg Hx																							
Details:																							
Age of onset:																							
Comments:																							

Medical History (mark all that apply)

Anemia	☐ Yes ☐ No	Diabetes mellitus	☐ Yes ☐ No	Myocardial infarction	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Nerve/muscle disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Sickle cell anemia	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Substance abuse	☐ Yes ☐ No
CHF	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Clotting disorder	☐ Yes ☐ No	Immune Reconstitution Inflammatory Syndrome	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
COPD	☐ Yes ☐ No			Ulcers	☐ Yes ☐ No
Depression	☐ Yes ☐ No				

Socioeconomic History (mark all that apply)

Occupation: _____ Employer: _____

Marriage status: _____ Spouse name: _____

# of children: _____

Years of education: _____ Comments: _____

Language: _____

Ethnicity: _____

Race: _____

Healthcare Directive

Healthcare Directive: ☐ Yes ☐ No ☐ Unknown Comments:

Type of Healthcare Directive ☐ Colorado CPR Directive ☐ Colorado MOST Form ☐ Living Will (e.g. Five Wishes)
☐ Medical Durable Power of Attorney (MDPOA) ☐ Other (comment)

Additional Type of Healthcare Directive: _____

Copy in chart: ☐ Yes, copy in chart ☐ No, copy requested ☐ Other (comment)

Medical Durable Power of Attorney: Name: _____ Phone: _____

If no MDPOA, then medical proxy: Name: _____ Phone: _____

Proxy to make anatomical give/organ donations: ☐ Yes ☐ No
Name: _____ Phone: _____

Healthcare directive information requested: ☐ Yes ☐ No

Healthcare directive information provided: ☐ Yes ☐ No

Person to make visitor decisions: Name: _____ Phone: _____

Pharmacy Selection

Most medication prescriptions can be sent directly to your pharmacy of choice. Please list all pharmacies that you use so that we can ensure they are in your record.

Name	Phone	Mail Order?	30 Days	90 Days
Atrium Pharmacy	720-848-4083	_____	☐	☐
AOP Pharmacy	720-848-1020	_____	☐	☐
Mail Order Pharmacy	720-848-1432	_____	☐	☐
Lowry Pharmacy	720-848-9590	_____	☐	☐

Other: _____

_____