

PATIENT HISTORY

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.



Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor		Email Address		
Patient's Social Security Number		Colorado Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Other Physician's Name				
Reason For Visit		Whom May We Thank for Referring You to Our Practice?		
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with you)				
Home Telephone		Work Telephone		
GENERAL MEDICAL HEALTH				
Bleeding & Scarring Tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid-hypo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bulging of the Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Keloid Former <input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid-hyper	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____ _____ _____
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bulging of the Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PAST SURGICAL PROCEDURES				
Date	Type	Comments		

Michael McCracken M.D.
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FACIAL PROCEDURES					
Date	Type	Comments			
MEDICATIONS					
Name of Medication	Amount	Times Per Day			
ALLERGIES					
REVIEW OF SYMPTOMS					
PLEASE CHECK ANY SYMPTOMS THAT YOU ARE EXPERIENCING NOW OR HAVE EXPERIENCED IN THE PAST.					
Chest Pain	<input type="checkbox"/>	Stomach Absorptive Disorder	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	Currently Breast Feeding	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Attention Deficit Disorder (ADD)	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Bleed Easily	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>
Fever or Chills	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
Nausea, Vomiting, Diarrhea	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Pulmonary Embolus	<input type="checkbox"/>
Unexpected Weight Loss or Gain	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Sinus Disorder	<input type="checkbox"/>	Limited Motion in Joints	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Hyperlipidemia	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>		
FAMILY HISTORY					
Malignant Hyperthermia	<input type="checkbox"/>	Anesthesia Problems	<input type="checkbox"/>	Alcohol Usage	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	Smoking	<input type="checkbox"/>
Abnormal Clotting	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>		
Signature of Patient, Parent, Guardian or Personal Representative				Date	
Please Print Name of Patient, Parent Guardian or Personal Representative				Relationship to Patient	

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