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HEALTH HISTORY FORM

Patient Name _____

Date of Birth _____ Today's Date _____

Past Medical History: _____

Other physicians involved in your care: _____

Past Surgical History: _____

Past Hospitalizations: _____

Current Medications –

Please list all current medications including OTC/Vitamins/Supplements/Birth Control that you take (name, dose, and how often you take it) on medication/Rx form attached. On No Medications

Allergies None _____

Past/Present Mental Illness/Depression: _____

Health Maintenance –

Date of last colonoscopy: _____

Date of last bone density: _____

Women Only:

Date of last menstrual period: _____

Date of last pap smear: _____

Date of last mammogram: _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Domestic Partner

Children/Age: # of female: _____ # of male: _____

Do you live alone? Yes No

Are you employed? Yes No Occupation: _____

Hobbies/Sports: _____

Have you ever used tobacco? Yes No Chew or Smoke? _____ How many/day: _____

Have you quit? Yes No What year? _____ Would you like information to help you with quitting? Yes No

Do you drink alcohol? Yes No How many drinks do you have weekly? _____

Do you currently use marijuana products? Yes No

Have you ever used/currently use recreational or street drugs? Yes No Explain: _____

Have you ever had/currently have a substance abuse problem? Yes No Explain: _____

Do you exercise? Yes No Which type? _____

How often do you exercise? _____

FAMILY HISTORY

Please indicate any health/mental illness problems your family members have had (past and/or present):

MOTHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
FATHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
SIBLINGS	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
MATERNAL GRANDMOTHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
MATERNAL GRANDFATHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
PATERNAL GRANDMOTHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER:
PATERNAL GRANDFATHER	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/> DIABETES <input type="checkbox"/> CANCER <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> THYROID	<input type="checkbox"/> OTHER: