GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

Jay W. McMurren, M. D. Lauretta F. Garren, M. D. Marie C. Matthews, M. D. John E. Holder, PA-C Nicol C. Talbert, PA-C

PAST MEDICAL HISTORY

Patient Name_____

Date of Birth_____ Date form was completed _____

Are you under care for any ongoing medical conditions? _____ Please list medical conditions: _____

_____

_____

Please list the names of any other doctors that you also see regularly: _____

_____

_____

Please list any serious accidents, surgeries, and/or hospitalizations that you have had (including date):

_____

_____

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

Do you have any medication allergies or intolerances? ☐ Yes ☐ No Please list: _____

_____

_____

FEMALE PATIENTS ONLY:

Number of Pregnancies: ____ Number of Deliveries: ____ Number of Elective Abortions: ____ Number of Miscarriages: ____

When was your last Pap? _____ Have you ever had an abnormal Pap? ☐ Yes ☐ No When?_____

Date of last Mammogram?_____ Have you ever had an abnormal Mammo? ☐ Yes ☐ No When?_____

Have you gone through menopause? ☐ Yes ☐ No What age? _____

Past History Illnesses: (Please Check)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Blood Transfusion
☐ Cancer
Type:_____
☐ Chemotherapy
☐ Chicken Pox
☐ Cholesterol Issues
☐ Circulatory Problems
☐ Chronic Pain
☐ Congenital Heart Problems
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ COPD
☐ Dementia
☐ Diabetes
☐ Eating Disorders
☐ Gall Bladder/Gall Stones
☐ Glaucoma
☐ Headaches (Migraine/other)
☐ Heart Murmur
☐ Heart Disease
☐ Hepatitis
Type:_____
☐ Hernia
☐ High Blood Pressure
☐ HIV/AIDS
☐ Liver Disease-Jaundice
☐ Lung Problems
☐ Kidney Disease
☐ Measles
☐ Mental Health
(Depression, anxiety, bipolar, etc.)
☐ Multiple Sclerosis
☐ Osteopenia/Osteoporosis
☐ Obesity
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease(s)
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcer
☐ Any other conditions:
_____

SOCIAL HISTORY

Marital Status: _____ Children: # of female:_____ # of male:_____

Are you homeless or in a dangerous living situation? ☐ Yes ☐ No Explain: _____

Do you live alone? ☐ Yes ☐ No Are you concerned about fall risk? ☐ Yes ☐ No

Do you have any concerns regarding your safety? ☐ Yes ☐ No Explain:_____

Do you need help with Daily Activities (shopping, cleaning, taking medications properly?) _____

Are you employed? ☐ Yes ☐ No Occupation: _____

Occupational exposures/hazards? (past or present) _____

How many sexual partners have you had in the last year?_____

Have you ever used tobacco? ☐ Yes ☐ No Which type? _____

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

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

Do you currently use recreational or street drugs? ☐ Yes ☐ No Explain:_____

Have you used recreational or street drugs in the past? ☐ Yes ☐ No Explain: _____

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

Do you get regular exercise? ☐ Yes ☐ No Which type? _____

How often do you exercise? _____

Are you on a special diet (Vegetarian, Diabetic, etc.)? ☐ Yes ☐ No Explain: _____

IMMUNIZATION HISTORY (List Dates)

☐ Yes ☐ No Measles, Mumps, Rubella (MMR) Vaccine _____

☐ Yes ☐ No Tetanus, Diphtheria, Pertussis (Td/Tdap Vaccine _____

☐ Yes ☐ No Hepatitis A Vaccine _____

☐ Yes ☐ No Hepatitis B Vaccine _____

☐ Yes ☐ No Varicella (Chicken Pox) Vaccine _____

☐ Yes ☐ No HPV (Human Papilloma Virus) Vaccine_____

☐ Yes ☐ No Flu Vaccine _____

☐ Yes ☐ No Pneumovax _____

☐ Yes ☐ No Prevnar _____

☐ Yes ☐ No Shingles (Zostervax) Vaccine _____

FAMILY HISTORY

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

Father:_____

☐ Alive ☐ Deceased Why?/When? _____

Mother: _____

☐ Alive ☐ Deceased Why?/When? _____

Brother(s): _____

☐ Alive ☐ Deceased Why?/When? _____

Sister(s): _____

☐ Alive ☐ Deceased Why?/When? _____

Do you have any family history of mental illness? ☐ Yes ☐ No Explain: _____

Do you have any other genetic family diseases?: _____

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MEDICATION/RX FORM

Patient Name______________________________

Date of Birth______________________ Date form was completed ______________________

Medication Rx & OTC	Dosage	Frequency	Reason for Use