Colorado Mountain Medical
Doctors you know and trust.
A partner of Vail Health

PATIENT HEALTH HISTORY FORM

FOR NEW PATIENTS TO: WILLIAM FOUTZ MD, & MARK STEPHENS MD

***Returning patients only need to fill out any changes since your last physical exam (recent surgeries, current meds, new diagnosis, etc.)**

Name	Age

CURRENT MEDICATION(S) / DOSE:

VITAMINS / SUPPLEMENTS:

ALLERGIES AND DRUG REACTIONS:

MAJOR HEALTH CONDITIONS

Please check all health conditions that apply:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease/Stones
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Ulcers
- ☐ High Blood Pressure
- ☐ COPD
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Migraines
- ☐ Blood Clots
- ☐ Depression
- ☐ Heartburn
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Thyroid
- ☐ Other:

05.12.20

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SURGERY HISTORY TYPE / DATE

WOMEN ONLY

Last menstrual period?	Normal? ◯ **Yes** ◯ **No**	If no:
If menopausal, did period cease? ◯ **Yes** ◯ **No**	Approximate Year	
Have you ever been pregnant? ◯ **Yes** ◯ **No**	If yes, how many times?	
Do you have any children? ◯ **Yes** ◯ **No**	If yes, how many?	
Last pap smear?	Normal? ◯ **Yes** ◯ **No**	If no:
Last mammogram (if >40yrs)?	Normal? ◯ **Yes** ◯ **No**	If no:
Last bone density (if menopausal)?	Normal? ◯ **Yes** ◯ **No**	If no:
Last colonoscopy (if >50yrs)?	Normal? ◯ **Yes** ◯ **No**	If no:

MEN ONLY (OVER AGE 18)

Last PSA?	Normal? ◯ **Yes** ◯ **No**	If no:
Last colonoscopy?	Normal? ◯ **Yes** ◯ **No**	If no:

HEALTH CARE MAINTENANCE

Have you had the following vaccines?

Tetanus ◯ **Yes** ◯ **No**	If yes, approximate date/year?:
Influenza ◯ **Yes** ◯ **No**	If yes, approximate date/year?:
Pneumovax (if >65yrs) ◯ **Yes** ◯ **No**	Shingles Vaccine (if >60yrs) ◯ **Yes** ◯ **No**

Last eye exam, approximate date or year?

Last dental exam, approximate date or year?

Last hearing check (if >65yrs), approximate date or year?

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Hometown		
Education - Mark highest level of school completed: ☐ **High School** ☐ **College** ☐ **Other:**		
Travel history - Please list:		
Military Service? ◯ **Yes** ◯ **No**	If yes, please describe	
Do you currently smoke? ◯ **Yes** ◯ **No**	If yes, how much?	Or how many years?
Would you like to quit? ◯ **Yes** ◯ **No** **OR** ◯ **Need more info.**		
If no, did you ever smoke? ◯ **Yes** ◯ **No**	When did you quit?	
Do you currently drink? ◯ **Yes** ◯ **No**	If yes, how much?	
If no, did you ever drink? ◯ **Yes** ◯ **No**	If yes, how much?	
Have you ever had any problems with addiction? ◯ **Yes** ◯ **No**		
What kind of work do you do?		
How long have you lived in this area?		
Do you exercise? ◯ **Yes** ◯ **No**	If yes, what kind and how often?	
Marital Status?		
Have you ever been abused physically, verbally or sexually? ◯ **Yes** ◯ **No**		
Do you feel threatened in any of your relationships? ◯ **Yes** ◯ **No**		
Do you have a living will? ◯ **Yes** ◯ **No** **OR** ◯ **Need more info**		
Do you have a medical power of attorney? ◯ **Yes** ◯ **No** **OR** ◯ **Need more info**		

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FAMILY HISTORY

Check all that apply and give details where appropriate.

	LIVING?	AGE(S)	IF DECEASED: AGE/CAUSE	CANCER	DIABETES	HEART DISEASE	HYPERTENSION
MOTHER	◯ Y ◯ N						
FATHER	◯ Y ◯ N						
SIBLINGS	◯ Y ◯ N						
	◯ Y ◯ N						
	◯ Y ◯ N						
	◯ Y ◯ N						
CHILDREN	◯ Y ◯ N						
	◯ Y ◯ N						
	◯ Y ◯ N						
	◯ Y ◯ N						

PRE-OP VISITS ONLY

Check all that apply and give details where appropriate.

Previous surgical complications? ◯ **Yes** ◯ **No**	If yes, please specify?
Personal or family history of bleeding disorders? ◯ **Yes** ◯ **No**	If yes, please specify?
Can you walk up a flight of stairs? ◯ **Yes** ◯ **No**	If no, why not?

Please list any additional health concerns you would like to discuss today: