Town Clinic of Crested Butte, PLLC

P.O. Box 1546
Crested Butte, CO 81224

214 6th Street, Suite 1
(970) 349-6749

Eric Thorson, M.D.

New Patient Health History

Last Name:_____ First Name:_____ DOB: __ __/__ __/__ __ __ __
m m d d y y y y

Would you like to have Dr. Thorson as your Primary Care Provider (PCP)? Y N

Past Medical History: (please mark any that apply and explain)

- ☐ Abdominal complaints
- ☐ Anxiety
- ☐ Arthritis / Joint pains
- ☐ Asthma / COPD / Chronic cough
- ☐ Back disorders
- ☐ Cancer
- ☐ Chronic pain
- ☐ Depression
- ☐ Diabetes
- ☐ Gynecologic disorders
- ☐ Headaches / Migraines
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Other (*please explain below*)

Explanation:_____

_____

Past Surgical History: (please list any surgeries and the date performed)

Surgery type	Date
1.	
2.	
3.	
4.	
5.	

Medications: (please include over the counter, herbal supplements, and birth control)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

Allergies: ☐ Drug/medication allergies (*please explain below*):

- ☐ No known drug allergies
- ☐ Animals ☐ Food
- ☐ Environmental
- ☐ No allergies at all

Explanation:_____

_____

_____

Turn over for page 2.

Review of Systems: (please check the system(s) and circle the condition(s) that applies to you today)

- ☐ **Breasts**: Skin changes, mass, pain, discharge
- ☐ **Ears**: Hearing loss, ringing, pain, discharge
- ☐ **Eye**: Visual change, blurred vision, glasses
- ☐ **Endocrine**: Heat/cold intolerance, excessive sweating, frequent urination, excessive thirst, thyroid problems, diabetes
- ☐ **GI**: Stomach-ache, nausea, vomiting, diarrhea, constipation, blood in stool, hemorrhoids, hepatitis
- ☐ **General**: Fever, chills, weight change, weakness
- ☐ **Genital**: Discharge, STDs, sores, abnormal periods, pain with intercourse, impotence
- ☐ **Head**: Trauma, headache
- ☐ **Heart**: Chest pain, high blood pressure, murmurs, palpitations, swelling, trouble lying flat
- ☐ **Hematologic**: Anemia, easy bruising, bleeding, transfusions
- ☐ **Lungs**: Short of breath, wheeze, cough, asthma, pneumonia, COPD
- ☐ **Mouth / Throat**: Sore, hoarseness, cavities
- ☐ **Muscles / Bones**: Weakness, pain, joint stiffness, arthritis, gout
- ☐ **Neuro**: Dizziness, loss of sensation, weakness, tremor, tingling, fainting
- ☐ **Nose**: Runny, blood, sneezing, itchy
- ☐ **Psychiatric**: Depression, anxiety, tension, memory difficulty
- ☐ **Skin**: Rash, hair change, nail change, moles
- ☐ **Urine**: Painful, frequency, discharge, blood
- ☐ **Vessels**: Leg swelling, painful walking, varicose veins, history of blood clots
- ☐ **Other**: (Please explain):_____

Explanation:_____

Family History: Please list illnesses or conditions that <u>any members</u> of your family may have/had (e.g., cancer, diabetes, heart disease, high blood pressure, etc.).

Mother:_____
Father:_____
Siblings:_____

Social History:

Married: Y N Separated Divorced Widow
Children: Y N How many:_____
Race (please list):_____
Ethnicity (circle): Hispanic/Latino or Not Hispanic/Not Latino
Preferred Language (please list):_____
Tobacco: Y N Never smoker Former Smoker
If Yes, Type:_____, How much per day:_____
Alcohol: Y N If Yes, How much per week:_____
Illegal drugs, including IV drug use: Y N If Yes, Which substances:_____
Working: Y N If Yes, Employer Name:_____
Exercise: Y N If Yes, Type:_____, How often:_____

Other important factors to your health history:

_____

Today's Date:_____

Staff Use Only						
Temp	**BP**	**Pulse**	**Sat.**	**RR**	**Ht.**	**Wt.**