James C. Garlitz, MD

Date of Appointment: _______________

Front Range Surgical Associates
8300 Alcott St., Suite 201
Westminster, CO 80031
303-428-0004 phone
303-428-1539 fax

Confidential Health Questionnaire

I appreciate the opportunity to participate in your medical care. It is very helpful if you fully answer these questions before you are seen. Thank you for your assistance.

Name: ____ Date of Birth: _______________ Age: ________

Ht: ________

Who is your regular doctor? ____

Who referred you to us? ____ Wt: ________

What is the reason you are seeing the doctor today? Briefly describe your symptoms.

____

____

____

Do you have any medication allergies or intolerances? Please list them here. ___________________________

____

What medications are you currently taking? (Please include dosage and frequency, if known.)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Do you use any non-prescription or over-the-counter medications, herbal or nutritional supplements? (Please include dosage and frequency, if known.) ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Place a check mark next to any current medical problems you have, or have been treated for in the past? Please include approximate dates and explain in the space provided. For example, □ pneumonia in 1995, etc…

□ anemia _______________ □ diabetes __________ □ high blood pressure ______ □ pancreatitis _________

□ asthma/emphysema_____ □ heart attack _______ □ high cholesterol _________ □ ulcers/reflux ________

□ bleeding problems ______ □ heart failure _______ □ kidney disease __________ □ colitis _______________

□ blood clots ____________ □ atrial fibrillation _____ □ liver disease ____________ □ thyroid disease ______

□ cancer _______________ □ HIV/hepatitis ______ □ pneumonia _____________ □ constipation _________

□ none of the above- Please list here: ____

____

Do any of the above problems run in your family? Please explain below- who, and what problem?

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Please list any previous operations you have had and when they were performed.

1. ______________________________ __________ 4. ______________________________ __________

2. ______________________________ __________ 5. ______________________________ __________

3. ______________________________ __________ 6. ______________________________ __________

Are you married? YES NO What do you do for a living? ____

Do you use tobacco? YES NO If yes, _____ packs per day for _____ years? If quit, when? ____________

Do you drink alcohol? YES NO If yes, how much, how often? ____________________________________

Do you drink coffee/tea/cola? YES NO If yes, how much, how often? _____________________________

Do you use recreational drugs, marijuana, etc? YES NO How much, how often? _____________________

(Please continue on the reverse side)

NAME____

Please check the box if you are having any of the symptoms listed below. Please explain in the space provided.

GENERAL:
- ☐ fever
- ☐ chills
- ☐ fatigue
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

HEENT:
- ☐ hoarseness
- ☐ sinus pressure
- ☐ sore throat

LUNGS:
- ☐ cough
- ☐ shortness of breath
- ☐ wheezing

HEART:
- ☐ chest pain
- ☐ edema
- ☐ palpitations

GI:
- ☐ abdominal pain
- ☐ blood in stools
- ☐ change in stools
- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ incontinence of stool

URINARY:
- ☐ pain or burning
- ☐ blood in urine
- ☐ slow stream
- ☐ frequent urination
- ☐ incontinence of urine

ENDOCRINE:
- ☐ cold intolerance
- ☐ heat intolerance
- ☐ excessive thirst

MUSCLES/JOINTS:
- ☐ back pain
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle weakness

PSYCHOLOGICAL:
- ☐ anxiety
- ☐ depression
- ☐ insomnia

SKIN:
- ☐ hives
- ☐ rash

BLOOD:
- ☐ easy bruising
- ☐ lymphadenopathy

OTHER:
- ☐ ________________
- ☐ ________________
- ☐ ________________
- ☐ ________________

____
____
____

-- For women only -- Women's Health --

To allow me to fully address women's health concerns, please answer these additional questions.

Who provides your gynecologic care? ____

How old were you when you had your first period? __________

How old were you when you first got pregnant? (Please include miscarriages and terminations) __________

How old were you when you had your first child? __________

How many children do you have? _________ How old are your children? _________________________

Did you breast feed your children? YES NO (please circle)

Have you ever used birth control pills? __________ If so, for how long? __________

If you are presently using birth control, what form do you use? ____

Do you still get your period? YES NO If not, at what age did you stop? __________

Do you use hormone replacement? (i.e. estrogen or progesterone) YES NO What type? ____________

Has anyone in your family had breast cancer? YES NO If yes, please list their relationship to you and their approximate age at diagnosis. ____

____

When was your last mammogram? __________________

Do you regularly perform breast self-exam? YES NO

*** Thank you for taking the time to fill out this questionnaire. ***