Mountain View Family HealthCare
A DIRECT PRIMARY CARE PRACTICE

Patient History Form

Today's Date: ________________

Patient Name: ____DOB:__________________

Please answer these questions to the best of your knowledge.
** If you have any questions, **please star (*)** it so we can address at your visit.

PAST MEDICAL HISTORY

1. Check off the following diagnoses that you have **now** or have had **in the past**.
2. Please **circle** the diagnosis if this is a **current** problem for you.
3. Indicate **when** (i.e. childhood) you were diagnosed and any **specifics** (eg type of cancer).

Diagnosis:	Age/Details		Diagnosis:	Age/Details
☐ Chicken Pox			☐ Seizures	
☐ Measles			☐ Stroke	
☐ Mumps			☐ Blood clots in lung or leg	
☐ Rubella			☐ Abnormal bleeding	
☐ Scarlet Fever			☐ Anemia	
☐ Rheumatic Fever			☐ Thyroid disorder	
☐ COPD			☐ Hepatitis/liver disorder	
☐ Asthma			☐ Gall bladder problems	
☐ Allergies			☐ Reflux or ulcers	
☐ Eczema/skin rashes			☐ Colitis	
☐ Bronchitis			☐ Kidney disease	
☐ Pneumonia			☐ Rheumatoid arthritis	
☐ Tuberculosis			☐ Degenerative arthritis	
☐ Diabetes			☐ Gout	
☐ High blood pressure			☐ Glaucoma	
☐ High cholesterol			☐ Cancer:	
☐ Heart disease			☐ Parkinson's disease	
☐ Mitral valve prolapse			☐ Shingles	
☐ Heart murmur			☐ Prostate problems	
☐ Psychiatric disorders			☐ Chronic urinary infection	
☐ Depression/anxiety			☐ Irritable bowel syndrome	
☐ Migraine headaches			☐ Incontinence	

Other problems not listed:

____

____

2. SURGICAL HISTORY

	Procedure:	Date:
1.	____	________________
2.	____	________________
3.	____	________________
4.	____	________________

3. HOSPITALIZATIONS: (not including above surgeries or childbirth)

	Reason:	Date:
1.	____	_______________
2.	____	_______________
3.	____	_______________

4. GYNECOLOGIC HISTORY: (females only)

1. Total # pregnancies _____
   # live births ____ vaginal deliveries ____ C-sections ____ miscarriages ____ abortions ____
2. At what age did your menstrual periods begin? __________
3. At what age did your menstrual periods stop (menopause)? __________

5. SERIOUS INJURIES OR ACCIDENTS:

	Injury/accident:	Year:
1.	____	_______________
2.	____	_______________
3.	____	_______________

6. Have you ever had a blood transfusion? Yes No

If yes, what was the reason? ____________________________________ Year: __________

7. Do you routinely take antibiotics prior to procedures, such as dental visits to prevent heart or joint infections? Yes No

If yes, why? ____

What is prescribed? ____

FAMILY HISTORY

List any BLOOD relatives with the following issues. If grandparents or aunt/uncle, please specify whether this relative is on your mother's side (**maternal)** or father's side (**paternal**) and age at onset.

1. Diabetes:
   ____ Age at onset: _________
   ____ Age at onset: _________
2. High blood pressure:
   ____ Age at onset: _________
   ____ Age at onset: _________
3. Heart attack, angina, coronary bypass, or other:
   ____ Age at onset: _________
   ____ Age at onset: _________
4. Stroke:
   ____ Age at onset: _________
   ____ Age at onset: _________
5. Cancer:
   __________________________Type:__________________ Age at onset: _______
   __________________________Type:__________________ Age at onset: _______
   __________________________Type:__________________ Age at onset: _______

6. Are there any other illnesses that are common in your family? **For example:** high cholesterol, mental disorder, thyroid problems, gall bladder disease, gastrointestinal issues, bleeding or clotting disorders, depression, substance abuse, etc.

   Illness:_________________________________ Relation:___________ Age at onset: ________
   Illness:_________________________________ Relation:___________ Age at onset: ________
   Illness:_________________________________ Relation:___________ Age at onset: ________

SOCIAL HISTORY

1. Current Marital Status: Single Partner/Married Separated Divorced Widowed Other
2. What is your spouse/partner's name?____
3. How many times have you been married? ____
4. Years in current relationship: ____
5. What is your current method of contraception? _______________________________________
6. With whom do you live? ____
7. Please list your biological children, if any:
   1. _______________________________ Date of Birth _________ Living? Y N
   2. _______________________________ Date of Birth _________ Living? Y N
   3. _______________________________ Date of Birth _________ Living? Y N
   4. _______________________________ Date of Birth _________ Living? Y N
8. List any other children living in your home and ages: ___________________________________
9. Employment: Full time Part time Retired Other: _________________________________
10. Occupation: _________________________________ Employer: _________________________
11. Religious Affiliation: ____
12. Years of education/highest degree (include other education such as associates degree, technical or vocational school certifications) ____
13. Degree and/or major: ____
14. Hobbies: ____
15. Regular exercise: Yes No
    _________________________________ How often/duration? _________________________
    _________________________________ How often/duration? _________________________
16. Habits: **Please indicate amounts if marking Yes.**

    a. Do you drink caffeine? No Yes
       _____________ cups/glasses of coffee/tea/soda per day

    b. Do you now use, or have you ever used, tobacco? No Yes
       1. Cigarettes: age started ______ age stopped ______ amount/day:________
       2. Pipe or cigars: No Yes amount: _______________
       3. Smokeless tobacco No Yes amount: __________

    c. Do you drink alcohol? No Yes (if Yes, please specify # per day, week, or year)
       1. ________ beers per day/week/year
       2. ________ glasses of wine per day/week/year
       3. ________ ounces hard liquor (or mixed drinks) per day/week/year

17. Have you ever had problems with alcohol or drugs? No Yes
    Now _______ or in the past_______ ?
18. Do you currently use recreational drugs (includes marijuana)? No Yes
    If yes, what type(s)? ____

HEALTH MAINTENANCE (indicate date of most recent):

1. Physical exam: ______________________________
2. Cholesterol: ____________________ was it normal or elevated?
3. Diabetes Screen (sugar): ______________________ was it normal or elevated?
4. Colonoscopy: _________________________ precancerous polyps found? Yes / No
5. Vision exam: ________________________ Dental exam:______________________
6. Date of your **most recent immunizations**:
   Tetanus/Pertussis ___________ Pneumovax ___________ Influenza (Flu): ___________
   Hepatitis B (series of 3) ___________ Hepatitis A ___________ Zostavax: ____________
7. Women: Mammogram: _______________________ was it normal? Yes / No:_____________
   Dexascan (bone density):______________________ was it normal? Yes / No:_____________
   Pap smear: _________________________________ was it normal? Yes / No:_____________
8. Men: PSA (prostate cancer screening): _______________ was it normal? Yes / No
9. Do you have Advanced Directives? No Yes
   If yes, check which documents you have completed:
   ____living will ____durable power of attorney ____CPR directive

Please circle other treatment modalities you have used and indicate what the treatment was for:

Acupuncture ____
Physical therapy ____
Homeopathy ____
Herbal therapy (oriental or naturopathic) ____
Counseling ____
Chiropractic manipulation ____
Osteopathic manipulation ____
Nutrition counseling ____
Other (list): ____
____
____
____