Mountain Family Medicine

Your appointment date & time is: ___/____/_____@_____am pm. NAME (PRINT): _____
Please completely fully & return at least 2 days prior to appointment (Delay in appointment may result if not completed).
Bring any medical records such scans, labs, X-rays etc.

Patient Information **Bring Insurance Information & Photo ID to Office Visit**

Name:_____
Address:_____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
The best time to contact me is: _____☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name: _____ Employer_____ Work Phone_____
Person to contact in case of emergency_____ Phone_____

Referring Person or Doctor: _____ **Primary Care Doctor:** _____

Reason for visit: Please include when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? If you have pain, please describe below and include Location - Timing (constant, occasional, episodic, minuets/hours, a.m. /p.m.) – Quality of pain (ache, sharp, dull, burning, etc.). - What makes it worse/ better (eating, movement, straining, etc.)?

_____
_____
_____
_____
_____
_____
_____

Past Surgical History (please check all that apply & date of surgery)

Heart Bypass/ Heart Angioplasty/Stents_____	Neck Surgery _____	Thyroid _____
Hernia_____ Location_____	Back Surgery _____	Colon _____
Gallbladder _____	Hip Surgery _____	Stomach _____
Leg Bypass, R or L _____	Knee Surgery _____	Lung _____
Vein Surgery, R or L _____	Foot Surgery _____	Bladder _____
Carotid Surgery, R or L _____	Carpal Tunnel _____	D & C _____
Aortic Aneurysm _____	Breast Surgery _____	Prostate _____
Hysterectomy _____	Colonoscopy _____	Tubes Tied _____
Cataract/Eye _____	Gastroscopy _____	C-Section _____
Pacemaker _____	Tonsillectomy _____	
Other _____		

Past Medical History (please circle **Yes** for all that apply) (please circle **A** for all that are currently active)

Chest pain/angina	**Yes**	**A**	**Motion sickness**	**Yes**	**A**	**Irregular Heart**	**Yes**	**A**
High blood pressure	**Yes**	**A**	**Kidney disease**	**Yes**	**A**	**Vision problems**	**Yes**	**A**
Palpitations	**Yes**	**A**	**Any Liver disease**	**Yes**	**A**	**Any Hepatitis**	**Yes**	**A**
Shortness of breath	**Yes**	**A**	**Bladder Infections**	**Yes**	**A**	**Cancer**	**Yes**	**A**
Heart attack	**Yes**	**A**	**Thyroid disease**	**Yes**	**A**	**Depression**	**Yes**	**A**
Asthma	**Yes**	**A**	**Diabetes**	**Yes**	**A**	**Stroke/TIA**	**Yes**	**A**
HIV	**Yes**	**A**	**Anemia**	**Yes**	**A**	**Blood Disorder**	**Yes**	**A**
Bronchitis	**Yes**	**A**	**Arthritis**	**Yes**	**A**	**Seizures**	**Yes**	**A**
Tuberculosis	**Yes**	**A**	**Dentures**	**Yes**	**A**	**Anorexia**	**Yes**	**A**
Hernia	**Yes**	**A**	**TMJ syndrome**	**Yes**	**A**	**Scarring**	**Yes**	**A**
Ulcers	**Yes**	**A**	**Fibromyalgia**	**Yes**	**A**	**Pacemaker**	**Yes**	**A**
Nausea/Vomiting	**Yes**	**A**	**MRSA**	**Yes**	**A**	**Sinus problems**	**Yes**	**A**
Malignant Hyperthermia	**Yes**	**A**	**Sleep Apnea**	**Yes**	**A**	**Abnormal EKG**	**Yes**	**A**
Recreational Drugs	**Yes**	**A**	**Oxygen use**	**Yes**	**A**	**Cold Sores**	**Yes**	**A**
Neuropathy	**Yes**	**A**	**Varicose vein**	**Yes**	**A**	**Abnormal Healing**	**Yes**	**A**

Review of Systems (Please circle all that apply)

Constitutional: Fever, chills, night sweats, trouble swallowing, weight loss/gain _____lbs. over what time period_____

Skin: Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis

Eyes: Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration. Glaucoma

ENT: Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems

Cardiac: Chest Pain, Angina, Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test _____, Echocardiogram _____

Respiratory: Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.

GI: Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool everyday _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps, generally eat high or low fiber diet, high or low fat diet.

GU: Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes.

GYN: # of Pregnancies _____, # of Live Births _____, # of Miscarriages/Abortions _____, Last menstrual period _____, Painful intercourse, irregular, light, heavy, approx. age at menopause _____

Musculoskeletal: Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.

Neurologic: Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.

Psych: Depression, Anxiety, Psychosis, rehab for drug or alcohol abuse, Dementia, Bipolar

Endocrine: Excessive thirst or urination, Thyroid disease

Heme/Immune: HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder.

Veins / Blood clots: Deep venous thrombosis. Phlebitis. Pulmonary embolism Varicose veins

Medications: List all medications, dosages frequency, and include all natural supplements: _____

_____

_____

_____

Any Diet Pills: Yes No Latex Allergy: Yes No Xylocaine "caine" any local anesthetic Allergy: Yes No

Drug Allergies: _____

Environmental Allergies: _____

Social History: Check all that apply: Alcohol _____. How much _____ Tobacco- Smoke _____ Dip _____ Chew ____ How much & how long? _____ If you quit, when? _____

Live Alone _____ Employed _____ Disabled _____ Retired _____ Student _____ Homemaker _____ Married ____ Divorced ____ Widowed ____ Never Married _____

Substance Abuse History: Names of drugs: How much? How Often? _____

Any prior Transfusions? Yes ___ No ___ Any reactions-->describe_____

Family History: Please specify which family member (s): □ Cancer □ Bleeding Disorder □ Diabetes □ Hypertensions □ Heart Problems □ Aneurysm □ Stroke □ Varicose Veins Explain: _____

Additional Information: _____

_____

_____

_____

_____

Email Address:_____. By providing your email address, we will enroll you in our electronic health record system so you can access and view your health records online. This is a confidential and secure system so only you can access via a personal password that you create online. Be sure to secure your password.

_____ ____/____/_____

Patient Signature DATE

_____ ____/____/_____

Reviewed by Nurse Practitioner / Physician (Signature) DATE