Mountain Medical Center

FOR OFFICE USE ONLY:
□ACUTE TRAVELER □ACUTE LOCAL □APPLICATION TO ESTABLISH CARE Date____/____/_____

PATIENT INFORMATION:

Last________________ Suffix ___ First________________ Middle__________ Preferred Name__________

Mailing Address___________________________ Physical Address (if different)________________________

City_____________________________________ State____________________ Zip Code_________________

Home Phone___________________ Work Phone_____________________ Cell Phone___________________

Email Address (used for patient portal access & appointment reminders)________________________________

Date of Birth_____/_____/________ Sex______ Gender______ Social Security Number_____-____-______

Marital Status………………………… □ Single □ Married □ Divorced □ Widowed

Preferred Language………………… □ English □ Spanish □ Other_________________

Race………………………………… □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Undisclosed

Ethnicity…………………………… □ Hispanic or Latino □ Not Hispanic or Latino

Do you give your consent to access your medical records though an online, secured patient portal? □ Yes □ No

Do you have an Advance Directive? □ Yes □ No (Please bring to your first office visit if yes)

Do you have any visual or hearing needs, preferences, or limitations? □ Yes □ No □ Explain________________

INSURANCE INFORMATION:

□ Check if uninsured (self-pay) and skip section

Primary Insurance Company Name______________________________Coverage Start Date_____________

Subscriber ID#___________________________ Group #_____________PCP Co-Pay Amt $______________

Subscriber Name (if different than patient)_________________________ Subscriber DOB: ____/____/_____

Secondary / Supplemental Insurance Name (if applicable)____

Subscriber ID#___________________________ Group #_____________PCP Co-Pay Amt $______________

RESPONSIBLE PARTY: (WHO DO WE BILL?)

□ Check if patient is financial guarantor & skip section

Name____________________________________ Phone Number______________________

Date of Birth_________/__________/___________ Social Security Number________-_________-________

Relation to Patient? □ parent □ spouse □ employer □ other ______________________

EMERGENCY CONTACT:

□ Check if same as responsible party & skip section

Name____________________________________ Relationship to patient________________

Address____Phone #________________________

Mountain Medical Center

PAGE 1 OF 2: PERSONAL HEALTH HISTORY QUESTIONNAIRE

Name: ______________________ Age:________ D.O.B.__________ Date:__________

Referred by Whom?______________________ Former Physician:______________________

FAMILY HISTORY: (FOR BLOOD RELATIVES – PLEASE INDICATE WHICH RELATIVE AND WHICH SIDE OF THE FAMILY)

			CANCER HISTORY………
□ Alcoholism ________	□ Epilepsy________	□ Migraine________	
□ Allergies________	□ Glaucoma ________	□ Mental Illness ________	□ Prostate________
□ Anemia________	□ Gout________	□ Skin Problems________	□ Breast ________
□ Arthritis________	□ Heart Disease________	□ Stroke________	□ Ovarian________
□ Asthma________	□ High BP________	□ Suicide ________	□ Colon________
□ Diabetes________	□ Kidney Problems________	□ Thyroid Dis.________	□ Other________

____

____

PAST MEDICAL, ILLNESS, INJURY, AND SURGICAL HISTORY:

Year	Illness or Operation	Year	Illness or Operation

MEDICATIONS: Please list all current medications, vitamins, and supplements.

ALLERGIES: Please list all known allergies, especially to medication. Please include medication side effects.

____

____

IMMUNIZATIONS: List approximate year of last immunizations

Tetanus__________ Pneumonia ________ Flu ________ Hepatitis__________ MMR________ Polio________

HEALTH CARE MAINTENANCE:

When was your last thorough health examination?____________ Where?______________________

When was your last: Pap Smear______________ Mammogram______________

Chest X-ray____________ Prostate Check______________ Colonoscopy / Sigmoidoscopy________

Treadmill Test____________ PSA______________ Cholesterol Check______________

Blood Count____________ Thyroid Test______________ Liver/Kidney/Electrolytes__________

SOCIAL HISTORY

Marital History: □ Single □ Married □ Divorced □ Separated □ Widowed

Tobacco History: □ Never □ Current __ Packs/Day □ Former: quit in______ □ Prev ______ Packs/Day

□ Chewing tobacco – How long?_______

Alcohol History: □ None □ Rare □ Drinks per day ______ □ Beer □ Hard Liquor □ Wine

□ Problems – yr ____________ □ History of Detox/rehab □ History of DUI

Recreational Drug Hx: □ None □ Marijuana □ I.V. Drugs □ Other____________

Caffeine: □ Coffee ____ cups/day □ Soda pop ____ cans/day □ Tea _____ cups/day

Current Occupation: ______________________________

Former Occupations: ______________________________

Exercise: (type and frequency)_ ______________________________

FOR OFFICE USE ONLY: **Date Reviewed: ________________________** **Initials of Reviewer_____________**

☐ **Patient Accepted to Establish Care at MMC** ☐ **Patient Not Accepted to Establish Care at MMC**

MEDICAL HISTORY – REVIEW OF SYMPTOMS

This is to give a good outline of types of past or current problems you have or have had in the past.
Write "C" for a current problem and "P" for a past problem next to the line.

MAIN CONCERNS: (1)______________________________ (2)________________________(3)________________________

GENERAL CONCERNS
□ Fevers / Chills / Night Sweats
□ Weight Gain - Recent
□ Weight Loss – Recent
□ Appetite – Increase/ Decrease
□ Chronic Fatigue
□ Sleep Difficulty
□ Snoring
□ Headaches – Migraine/Tension
HA Frequency _____
□ History of Physical/Sexual/ Spousal Abuse

EYE CONCERNS
□ Wear Contacts or Glasses
□ Double or Blurry vision
□ Failing or loss of vision
□ Eye Pain
□ Floaters
□ History of Cataracts
Surgery Date____________

EAR/NOSE/THROAT CONCERNS
□ Ear Pain
□ Decreased Hearing
□ Use Hearing Aids
□ Ringing in Ears
□ History of Frequent Ear Inf.
□ Dizzy Spells / Vertigo
□ Sinus Pain
□ History of Sinus Infections
□ Hay Fever / Allergies
□ Problems with Nose Bleeds
□ Sore Throat / Oral Ulcers
□ Voice Change / Hoarseness
□ Difficulty Swallowing
□ Dental Problems

LUNG CONCERNS
□ Cough – Recent / Chronic
□ Bronchitis – Recent / Chronic
□ Shortness of Breath
□ Pain with Breathing
□ History of Asthma
□ History of Weak Lungs
□ History of Pneumonia or Pluerisy
□ History of Intubation

HEART CONCERNS
□ Chest Pain / Angina
□ Palpitations / Racing Heart
□ Irregular Heartbeat
□ High Blood Pressure
□ Heart Attacks
□ Heart Murmur / Valve Prob.
□ Swollen Ankles / Edema

GASTROINTESTINAL BOWEL
□ Abdominal Pain
□ Heartburn / Acid Reflux
□ Ulcers
□ Hepatitis / Liver Problems
□ Persistent Nausea / Vomiting
□ Persistent Diarrhea
□ Bloody or Tarry (Black) Stools
□ Change in Bowel Habits
□ Constipation
□ Hemorrhoids
□ Rectal Pain
□ Diverticulosis
□ Diverticulitis
□ Gall Bladder Problems
□ Hernia

ORTHOPEDIC CONCERNS
□ Joint Pain ________________
□ Joint Swelling_____________
□ Neck or Back Pain – recurrent
□ Leg or Arm Pain
□ Numbness / Tingling
□ Weakness_________________
□ Arthritis __________________
□ Easy Fractures

OSTEOPOROSIS HISTORY
□ Loss of Height
□ Osteoporosis
□ Osteopenia
□ Have been on Meds for Osteoporosis. If so, list them:
____
□ History of Compression Fractures
□ History of Hip Fractures
Last Dexa Scan:___________

NEUROLOGY
□ Headaches – Tension
□ Headaches – Migraine
Headache Frequency________
□Previous Treatments for Headaches________________
□ Tremors
□ Balance Problems

DERMATOLOGY / SKIN CONCERNS:
□ Hives
□ Eczema / Psoriasis / Rashes
□ Easy Bruising
□ Skin Cancers
□ Pre-Cancerous Skin Lesions

PSYCHIATRIC / MENTAL ILLNESS:
□ Depression / Irritability
□ Anger Problems
□ Anxiety / Nervousness
□ Hospitalization for Mental Illness
□ Counseling
With Whom?______________
□ Prior Medications:__________
____

MENSTRUAL HISTORY / GYNE. CONCERNS:
□ Last Menstrual Period _______
□ Age Menses Began_________
□ No. of Pregnancies__________
□ No. of Live Births__________
□ No. of Miscarriages_________
□ No. of Abortions___________
□ Date of last PAP___________
Menses: Reg – Irreg – None
Menstrual Flow:
None – Light – Mod – Heavy
□Abn Pap? When:____________
□ Hysterectomy with or without Ovaries
□ Pain / Cramps with Menses
Days of flow________________
Length of cycle______________
□ Pain / Bleeding after Sex
□ Abnormal Vaginal Bleeding

□ History of Tubal Infections
□ History of Venereal / STD Inf.
If so, list_________________
□ History of Tubal Ligation
Birth Control Method_________
B.C. Pill Name_____________

BREAST HISTORY:
Date of Last Mammogram_____
□ Breast Cancer_____________
□ History of Fibrocystic Breasts
□ History of Abn Mammogram
When?___________________
□ History of Breast Ultrasound
Results:__________________
□ History of Breast Biopsy
Results:__________________

MENOPAUSAL HISTORY:
□ Duration__________________
□ Flushing / Hot Flashes
□ Night Sweats
□ Mood Swings
□ Depression / Irritability
□ Anxiety
□ Memory Problems
□ Palpitations / Rapid Heart Rate

PROSTATE HISTORY:
□ Vasectomy – Date:_________
□ Prostate Cancer____________
□ History of BPH (enlarged prostate)
□ History of Prostate Infections
□ History of Venereal / STD Inf.
If so, list_________________
□ History of Elevated PSA
□ History of Prostate Biopsy
Date of Biopsy____________
Results__________________

URINARY CONCERNS:
□ Urinary Infections – Frequent
□ Painful Urination
□ Blood in Urine
□ Loss of Urine / Leakage
□ Nighttime urination 2+ times
□ History of Kidney Stones

Synopsis of Medical History ____
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