MOUNTAIN VIEW MEDICAL CENTER
FAMILY PRACTICE

Patient Health History

NAME:_____ **BIRTHDATE:**_____
LAST FIRST M.I. MAIDEN

DRUG/FOOD ALLERGIES: ____NO _____YES

TO WHAT & REACTION: _____ **DATE:** _____

_____

MEDICATIONS: Please include: name, dose (including strength and/or # of pills p/day) and how long you have taken this medication.

1	5
2	6
3	7
4	8

PAST MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

- Cancer: _____
- Heart Disease:_____
- Ear/Nose/Throat:_____
- Skin: _____
- Musculoskeletal: _____
- Endocrine: _____
- Respiratory: _____
- Neurological: _____
- Psychiatric: _____
- Other: _____

PAST SURGICAL HISTORY: Please list all prior operations (with dates).

- Cardiac: _____
- Ear/Nose/Throat: _____
- Lung: _____
- Musculoskeletal: _____
- Urinary: _____
- Gastric: _____
- GYN: _____
- Other: _____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle):

- Cancer: _____
- Heart Disease: _____
- Diabetes / Kidney: _____
- Respiratory: _____
- Psychiatric: _____
- Other: _____

Other significant Illnesses/Injuries or non-surgical hospitalizations (Please List):

_____

_____

Are you under the care of any other physician? ___Yes ___No If yes, please list other physicians and what is being treated.

_____

_____

SOCIAL HISTORY:

DETAILS/

Occupation: _____ Employer: _____

Marital Status: Single, Married/Partner, Divorced, Widowed, Other

Spouse Name: _____ #of Children/ages: _____

TOBACCO USE:
Never ___, Quit Date _____
Current Smoker: packs/day _____, # years _____
Other tobacco: pipe___, cigar___, chew___, other_____
Are you interested in quitting? Yes___, No___

ALCOHOL USE:
Do you drink alcohol? Yes___, No___, # drinks p/day___, Type_____
Do you feel the need to cut down? _____, Been annoyed by complaints? _____
Felt guilty regarding drinking? _____, Need an eye opener in the am? _____

DRUG USE:
Do you use any recreational drugs? Yes___, No___, Type _____, How Long_____

EXERCISE:
Do you exercise regularly? Yes___, No___What kind of exercise? _____
How long (minutes)_____ How Often_____

SAFETY:
Is violence at home a concern for you? Yes___, No___
Have you ever been abused? Yes___, No___
Do you have a gun in your home? Yes___, No___

SEXUAL ACTIVITY:
Sexually Active: Yes___, No___, Not Currently___
Current sex partner(s) is/are: Male___, Female___
Birth control method: _____, None Needed ___
Have you ever had a sexually transmitted disease (STD)? No___, Yes___
Are you interested in being screened for sexually transmitted disease? No___, Yes___

WOMANS HEALTH HISTORY
Pregnancies _____ # Deliveries _____ # Abortions _____ # Miscarriages _____ # Living_____
Age at start of periods _____ Age at end of periods _____

GENERAL
Have you completed an advanced directive or POLST? (Physicians Orders for Life Sustaining Treatment)
Yes___
No ___

Do you have a medical marijuana card?
Yes___
No___

Do you have a pain contract for chronic pain?
Yes___ With which clinic?_____
No___

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Acknowledgement and Consent

I understand that Mountain View Medical Center (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-or-

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

For Office Use Only

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (Please Specify)

_____
_____

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