

**Mountain Health Care
Medical Information Sheet**

Today's Date:

Please answer the questions on both sides of this form.

It will help your physician provide better health care for you.

Name:		Address:			
Phone: ()	Date of Birth:	Age:	Birthplace:	Race/Nationality:	
Religion:	Education:	Occupation:		How long?:	
Marital Status:	Years present marriage:	Years previous Marriage:			

Where & when have you traveled outside the US or Canada?

Alive: >	Father	Present health or cause of death:	Mother	Present health or cause of death:	Spouse	Present health or cause of death:
Deceased >	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Brothers >	# Alive:	Health:	# Deceased:	Cause of death:
Sisters >	# Alive:	Health:	# Deceased:	Cause of death:
Children >	# Alive:	Health:	# Deceased:	Cause of death:

Check illnesses which have occurred in any of **your blood relatives**:

- Diabetes Cancer Bleeding Tendency Tuberculosis Asthma Heart disease
 Stroke High blood pressure Nervous Illness Allergy Other: _____

Check any illnesses or conditions that **you** have had:

Heart Disease Syphilis Vein Trouble Diabetes Cancer Glaucoma
 Gonorrhea Bleeding Tendency Tuberculosis Cancer Asthma Jaundice
 AIDS Rheumatic Fever Nervous Disorder Pneumonia Kidney Disease
 High Cholesterol Emphysema Other _____

List other illnesses requiring Hospitalization but not surgery:

Have you had any serious injuries, broken bones, etc: If yes, please list:

Do you have any allergies or sensitivity to medicines/other substances: If yes, please list:

Check the Diseases against which you have been immunized:

Smallpox Typhoid Tetanus Date of last Tetanus shot _____ Polio Influenza Pneumonia
 Diphtheria Pertussis Tuberculosis Chicken Pox Other: _____

Previous Operations: Please list Year, Hospital Names, and Surgeons:

MEDICATIONS: (List here or provide a copy of a list of medications you are currently taking or have taken recently)

Have you ever taken Cortisone/Steroid-type drugs?	Birth Control Pills?	Have you received a blood transfusion? If yes, please provide date: _____
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Dental: (List any problems/concerns you currently have)

For Women Only:

Onset date of last menstrual period _ / _ / _	Periods are: Regular <input type="checkbox"/> Irregular <input type="checkbox"/>	# of Pregnancies:	# of Miscarriages:
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PLEASE TURN FORM OVER

How would you rate your overall health on a scale of 1-10 (10 being very healthy)?		
Do you forget to take your medications?		
If so, How often? <input type="radio"/> Frequently <input type="radio"/> Occasionally <input type="radio"/> Seldom		
Do you have any hearing, vision, or learning problems?		(If yes, please list them:)
Do you have any special dietary needs or problems?		(If yes, please list them:)
How would you rate your Stress Level on a scale of 1-10 (0 being no stress, 10 being unbearable stress)?		
Do you have any difficulty sleeping?		
Have you ever had any of the following feelings more often than most people?		
<input type="radio"/> Anxiety <input type="radio"/> Helplessness <input type="radio"/> Isolation <input type="radio"/> Lack of control <input type="radio"/> Depression <input type="radio"/> Hopelessn <input type="radio"/> Fear <input type="radio"/> Anger <input type="radio"/> Guilt <input type="radio"/> Headaches		
Have you ever been <input type="radio"/> Abused? <input type="radio"/> A victim of a crime? <input type="radio"/> Experienced trauma (physical or emotional)		
Do you use tobacco now?	Type and daily amount?	How long?
In the past?		
Do you drink beverages with caffeine?	Type and daily amount: <input type="radio"/> Coffee <input type="radio"/> Tea <input type="radio"/> Soda	How long?
Do you drink alcoholic beverages?	Type and daily amount: <input type="radio"/> Beer <input type="radio"/> Wine <input type="radio"/> Liquor	How long?
Have you ever felt you should cut down on your drinking?	<input type="radio"/> Yes <input type="radio"/> No	
Have other people told you to cut down on your drinking?	<input type="radio"/> Yes <input type="radio"/> No	
Have you ever been in trouble due to your drinking ?	<input type="radio"/> Yes <input type="radio"/> No	
Have you ever had a drink first thing in the morning, or to get rid of a hangover?	<input type="radio"/> Yes <input type="radio"/> No	
Do you feel you are exposed to any Hazardous Materials or chemicals in your job or home?		
If yes, please explain:		
Do you feel you have a medical problem because of your job (present or previous)?		
If yes, please explain:		
What is your main medical problem and how long have you had it?		
What are your concerns today?		
Comments:		
Reviewed by : (Provider)		Date:
Notes:		