Patients Name:_____ Todays Date:_____

MOUNTAIN VIEW FAMILY MEDICINE

Medical History: (Please list illnesses, injuries, or other problems you have seen a doctor about)

_____

_____

Surgeries: (Please list any past surgeries you have had done. Where and When)

_____

_____

Hospitalizations: (Please list any overnight hospital stays…excluding normal pregnancies)

_____

_____

OB/GYN History: (Females)

Age of 1st Menstrual Cycle:_____Age of Menopause:_____Number of Pregnancies:_____
Full-term Births:_____Pre-term Births:_____Miscarriages:_____Living Children:_____
Type of Delivery:_____Pregnancy Complications:_____

Family History:

	Age if Living	Health Problems	Age and Cause of Death
Father			
Mother			
Sister(s)			
Brother(s)			
Children			

Prevention: (When was your last)

Tetanus Shot_____
Pneumonia Shot_____
Pap Smear_____
Mammogram_____
Cholesterol Check_____

Allergies to Past Medications:
_____
_____

What Happened:
_____

Habits and Activities:

Do you Drink Alcohol_____If yes…how much and how often_____
Do you Smoke or use Tobacco_____If yes…how much and how long_____Do you currently_____
Are Currently Exercising_____If yes…type and frequency_____
Hobbies and Leisure Activities_____

Medical Illnesses: (Please mark all that apply)

You	Family	Illness	You	Family	Illness
____	_____	Diabetes	____	_____	Thyroid Disease
____	_____	High Blood Pressure	____	_____	Gallbladder
____	_____	Heart Disease	____	_____	Liver Disease
____	_____	Stroke	____	_____	Ulcer
____	_____	Blood Clots	____	_____	Anemia or Bleeding
____	_____	Cancer	____	_____	Migraine Headaches
____	_____	Asthma or Allergies	____	_____	Arthritis
____	_____	Pneumonia or TB	____	_____	Osteoporosis
____	_____	Kidney Problems	____	_____	Bone Fracture
____	_____	Depression or Anxiety	____	_____	Sexually Transmitted Disease