Mountainview Medical Center

History and Physical Form

Name :_____Birth Date_____

ALLERGIES-(PENICILLIN, LATEX, MEDICATIONS etc) None / Yes List-

_____

_____

Current Medications (include over the counter and herbal)

MEDICATION	Dose	Frequency	**MEDICATION**	Dose	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Social History- Do you use alcohol? How Long / How much _____

Do you use caffeine? How long/ How much_____

Smokeless Tobacco: ____ Yes ____No How Much _____How often_____

Smoking: _____ cigarettes_____ cigars____ medical marijuana_____ E cigarettes/ vapor____

_____current every day _____some days _____former smoker_____ never smoked_____

Marital Status: _____ do you have children Y / N ages_____

Occupation_____ Hobbies _____

Exercise _____

FAMILY HISTORY REVIEW: (please list Relationship)

Alcoholism_____ Cancer_____ Mental Illness_____

Arthritis_____ Diabetes_____ Reaction to anesthesia _____

Asthma_____ Heart Disease_____ Stroke_____

COPD_____ Bleeding Clotting Disorder_____ High Blood Pressure _____

Have you been diagnosed with any of the following: (If there is more info, please use back of this sheet)

AIDS/HIV	Y / N	Hepatitis	Y / N	Stomach Ulcers	Y / N
Anemia	Y/ N	High Blood Pressure	Y /N	Spinal Cord Stimulator	Y / N
Asthma	Y / N	High Cholesterol	Y /N	Stroke	Y / N
Cancer	Y / N	Hypothyroidism	Y / N	Substance Abuse	Y / N
Congestive Heart Failure	Y / N	Insomnia	Y / N	Surgical Site Infection	Y /N
COPD	Y / N	Kidney Disease	Y /N	Tuberculosis	Y / N
Emphysema	Y / N	Obesity	Y / N	Urinary Tract Infection	Y / N
Coronary Artery Disease	Y / N	Osteoarthritis	Y / N	Women-Pregnant Now	Y / N
Deep Venous Thrombosis	Y / N	Osteoporosis	Y / N	Menopause	Y / N
Blood Clot	Y / N	Pacemaker	Y/ N	Men- Enlarged Prostate	Y / N
Depression	Y / N	Peripheral Vascular Disease	Y / N		
Diabetes	Y / N	Psychiatric Illness	Y / N	Other _____	
Fibromyalgia	Y / N	Rheumatoid Arthritis	Y / N	Other _____	
Heart Arrhythmias	Y / N	Seizures	Y / N		
Heart Attack	Y / N	Sleep Apnea	Y / N		
Heart Stent	Y / N	Do you use a CPAP	Y / N		