

High Mountain Healthcare

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Patient Health History

Patient Demographics	
Today's Date:	Date of Birth: Age:
Patient Name:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male

Reason for Visit
Please describe the primary problem/diagnosis:
Please list any secondary concerns:

Past Medical History/Review of Symptoms			
<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Obesity
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hand problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Allergies/Hay fever	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Head injury	<input type="checkbox"/> Prostate problem
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Arthritis/joint pain, swelling	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Rupture/hernia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Stomach problem
<input type="checkbox"/> Back problems	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Stroke
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> High blood pressures	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Kidney/bladder problems	<input type="checkbox"/> Thyroid disease/goiter
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Eczema, hives, rashes	<input type="checkbox"/> Liver disease, jaundice, hepatitis	<input type="checkbox"/> Transfusion reaction
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lung/breathing problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Eye problems /glaucoma/cataracts	<input type="checkbox"/> Muscle weakness	
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Foot problems	<input type="checkbox"/> Nervous problems/breakdown	

Other Past Serious Illnesses, Injuries, and Surgeries			
Date		Date	

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Patient Name: _____

Current Medications	
Please list all medications, vitamins, and supplements you are <u>now</u> taking with dosage and number of times per day, including those you buy with/without a prescription.	

Allergies	
Please list any allergies to medications, or anything else, including foods and latex. Describe your reaction.	

Immediate Family History (Father, Mother, Sister, Brother)			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer: Lung	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Respiratory (Breathing) problems
<input type="checkbox"/> Attention Deficit disorder	<input type="checkbox"/> Cancer: Other _____	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Cancer: Ovary	<input type="checkbox"/> Hematologic (blood) disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Cancer: Prostate	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer: Breast - mother	<input type="checkbox"/> Cancer: Skin	<input type="checkbox"/> Mental Health problems	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Cancer: Breast - sister	<input type="checkbox"/> Cancer: Stomach	<input type="checkbox"/> Migraines	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Cancer: Breast - other	<input type="checkbox"/> CAD (Heart problems)	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Toxemia
<input type="checkbox"/> Cancer: Colon - parent	<input type="checkbox"/> DVT (Blood clots in legs)	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer: Colon - sibling	<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney cysts	<input type="checkbox"/> Vision loss
<input type="checkbox"/> Cancer: Colon - other	<input type="checkbox"/> Depression	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> No significant family history
<input type="checkbox"/> Cancer: uterine/cervical	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> PE (Blood clots in lungs)	<input type="checkbox"/> Not available

Social History	
Do you live alone? Y N Whom do you rely on for emotional/social support?	Are you able to care for yourself without the assistance of anyone else? Y N If no, please explain:
Do you feel safe at home? Y N Have you been emotionally, physically or sexually abused? Y N	Have you had any changes in your life that could affect your coping abilities? (e.g. job, move, divorce, death, disabilities) Y N If yes, please explain:
Have you used tobacco products? Y N How many years? _____ Quit? Y N How many packs/pipes/chew/dip per day? _____	Do you drink alcohol? Y N How often? _____ Have you ever had a problem with alcohol? Y N
Have you ever used drugs? Y N Have you ever smoked marijuana? Y N Have you ever used "hard" drugs? Y N Please describe usage:	Do you consider your diet healthy and well balanced? Y N Please list all food/beverage intake over the past 24 hours:
Occupation: _____ Retired: Y N Number of children: _____ Marital Status: [] Married [] Single [] Widowed [] Divorced [] Other	Please describe your exercise routine: