

High Mountain Healthcare

T. Michele Thompson, MD Cynthia J. Libert, MD Dinah M. Conti, MD
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BLAIRSVILLE, GA 30514

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
Please list any Past Medical History problems:

Other Past Serious Illnesses, Injuries, and Surgeries			
Date		Date	

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.	

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Patient Name: _____

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

Birth History	
Vaginal or Caesarean Section (circle one) If Caesarean Section Why: _____	Birth Weight: _____ Hospital Discharge Weight: _____
Full Term Y/N If not Full Term Birthed at _____ Weeks.	Birth Problems or Complications: _____ _____ _____
Was baby circumcised Y / N If so when: _____	