



MEDICAL HISTORY

NAME: _____ DATE: _____

YOUR SYMPTOMS

What is the reason for your visit? _____

Is your visit the result of a work related injury? _____ If yes, please provide claim information

In the last 2 weeks have you had:

- | | |
|---|--|
| ☐ fever/chills | ☐ dizziness |
| ☐ fainting | ☐ nausea/vomiting |
| ☐ low blood pressure | ☐ diarrhea |
| ☐ weight loss | ☐ abdominal pain |
| ☐ chest pain | |

PREVIOUS MAJOR SURGERIES

Date and Type of surgery:

SAFETY

With whom do you live? _____ Do you feel safe in your home? _____

Have you fallen in the last year? _____ If yes:

How many times? _____ Were there any injuries? _____

TOBACCO/ALCOHOL HISTORY

Do you use smokeless tobacco? _____

Do you smoke cigarettes or vape? _____ If yes to either:

When did you start? _____ How often? _____

How many cigarettes/day? _____ How soon after waking? _____

Are you interested in quitting? _____

Do you drink alcohol? _____ If yes:

How often? ___ daily ___ 2-3 x weekly ___ 2-3 x monthly ___ once monthly

How many drinks at one time? _____

How often in the last year did you have 6 or more drinks in one day? _____

Recreational drugs? _____ Marijuana use? _____ If yes, how often? _____

FAMILY HISTORY

Do you have any family history of the following: (Specify which family member)

Diabetes _____ High blood pressure _____ Heart disease _____

High cholesterol _____ Colon cancer _____ Breast cancer _____

Lung disease _____ Mental health issues _____

YOUR HEALTH

Do you have any of the following medical problems?

- ☐ AIDS/HIV/Hepatitis
- ☐ Immune Disorder Specify: _____
- ☐ Anemia
- ☐ Cancer Specify: _____
- ☐ Heart disease
- ☐ Coronary Artery disease
- ☐ Diabetes Type I _____ Type 2 _____
- ☐ Epilepsy/seizures
- ☐ Migraines/frequent headaches
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease Specify: _____
- ☐ Liver disease Specify: _____
- ☐ Lung disease Specify: _____
- ☐ Nerve disorder Specify: _____
- ☐ History of stroke
- ☐ Gastric reflux/heartburn
- ☐ Substance abuse
- ☐ Are you pregnant? Yes _____ No _____ Possibly _____

ALLERGIES

- ☐ No known allergies

Please list any medication allergies and your reaction:

Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____

MEDICATION INFORMATION

Please list all medications you are currently taking. It is **very important** that you include blood thinners and weight loss medications:

[illegible]



PERSONAL & HEALTH INFORMATION PRIVACY POLICY

YOUR PERSONAL AND HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

☐ I have read, understood, and agree to this Privacy Policy.

☐ Patient Name (printed): _____ Signature: _____ Date: _____



PERSONAL INFORMATION

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms.

☐ Jr. ☐ Sr. ☐ III

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Social Security # _____ Email: _____ Email reminders? ☐ Y ☐ N

Mailing Address: _____

City: _____ State: _____ Zip: _____

Pharmacy: _____ Primary Care Physician: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Language: ☐ English ☐ Other: _____

Race: ☐ White ☐ Alaska Native ☐ African American ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ NOT Hispanic/Latino

Is it OK to leave a message about your appointment?

Home Phone: _____ ☐ Yes ☐ No

Cell Phone: _____ ☐ Yes ☐ No

Work Phone: _____ ☐ Yes ☐ No

Emergency Contact Name: _____ Authorized for HIPPA info? ☐ Yes ☐ No

Emergency Contact Phone: _____ Relationship: _____

PERSON RESPONSIBLE FOR THE BILL

☐ SAME AS ABOVE (if not, fill out below)

Full Name: _____ Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy#/Member ID/Subscriber #: _____ Policy#/Member ID/Subscriber #: _____

Name on card: _____ Name on card: _____

Date of birth of policy holder: _____ Date of birth of policy holder: _____

I authorize Mountain View Surgery to bill my insurance on my behalf: _____

Signature

I authorize Mountain View Surgery to obtain external prescription history _____

Initials