MOUNTAIN VIEW
Medical Associates

Personal History

Marital Status	Single Married Divorced Widowed		
Biologic Father	Age	Health Status	
Biologic Mother	Age	Health Status	
Biologic Brother	Age	Health Status	
Biologic Sister	Age	Health Status	
Biologic Children	Age Age Age	Health Status Health Status Health Status	

Who are the members of your household?

Are you responsible for another's care?

Have you traveled to another country in the last 4 years? If so, where?

What is your current occupation?

What other kinds of work have you done?

What training or education have you had?

Do you have beliefs or traditions which effect diet or medical care:

Do you have a Living Will?

Does anyone have your Power of Attorney for medical decisions?

Patient Name:

Family History (please check all that apply)	**Parents**	**Siblings**	**Self**
Heart Problem			
High Pressure			
High Cholesterol			
Thyroid Problems			
Anemia			
Diabetes			
Stroke			
Cancer			
Tuberculosis			
Asthma			
Lung Disease			
Kidney Stones			
Drug Problems			
Alcoholism			
Mental Illness			

RISK ASSESSMENT

Do you use sunscreen? _____

Do you wear a seatbelt? _____

Do you use tobacco? No

Yes (circle which one) Cigar Pipe Cigarettes Chew

How Often? _____ How long? _____

Have you ever quit? Y N

Do you exercise regularly? Y N

Yes How many times a week? _____

Do you follow a special diet? Y N

Do you keep a gun at home? Y N Is it locked? Y N

Has anyone at home ever hit or injured you? Y N

Are you sexually active? Y N

Do you practice "safe sex"? Y N

Have you had any blood transfusions? Y N When?

Date of Birth:

During the Past Year:	Yes	No
Has there been a significant increase in the number of days you feel sad or “down”?		
Have you lost interest in activities you used to enjoy?		
Have you had more difficulty with sleep?		
Have you felt you should cut down on drinking?		
Have others criticized your drinking?		
Have you felt guilty about drinking?		
Have you had a morning drink to steady your nerves?		

Have you experienced any of the following? *(please circle all that apply)*

Weight Gain/Loss	Change in Bowel Habits	Jaundice	Change in a Mole
Indigestion	Joint Pain	Skin Problems	Blood in Stool
Back Pain	Vision Problems	Difficulty Swallowing	Muscle Cramps
Hay Fever	Heath/Cold Tolerance	Weakness	Sinus Problems
Frequent Urination	Leaking of Urine	Shortness of Breath	Excessive Thirst
Excessive Fatigue	Palpation/Chest Pain	Bruising or Bleeding	Difficulty Sleeping

If needed, what life style changes are you prepared to make?

For each question below, circle the number to the right that best fits your feelings. Use the scale to the right

Question	Scale				
Stop Smoking?	1	2	3	4	5
Change Diet?	1	2	3	4	5
Lose Weight?	1	2	3	4	5
Exercise?	1	2	3	4	5
Reduce Stress?	1	2	3	4	5
Change Alcohol Intake?	1	2	3	4	5

1	Already Made Change
2	Ready to Change
3	No Opinion/Don’t Know
4	Not Ready/Want Change
5	Not Ready/ Don’t Want to Change

Patient Name: **Date of Birth:**