MOUNTAIN VIEW MEDICAL ASSOCIATES
HEALTH ASSESSMENT

PATIENT NAME:______________________________________

DATE:____________________________

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_____ Health Status_______

Age_____ Health Status_______

Age_____ Health Status_______

Who are the members of your household?
____
____

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 affect diet or medical care?
____

Do you have a Living Will? Yes No

Does anyone have your Power of Attorney for medical decisions? Yes No

FAMILY HISTORY Please check all that apply	Parents	Siblings	Self
Heart Disease			
High Blood Pressure			
High Cholesterol			
Thyroid Problems			
Anemia			
Diabetes			
Stroke			
Cancer			
Tuberculosis			
Asthma			
Lung Disease			
Kidney Stones			
Drug Problems			
Alcoholism			
Mental Illness			

RISK ASSESSEMENT:

Do you use sunscreen? Yes No

Do you wear a seatbelt? Yes No

Do you use tobacco? Yes No
If yes, circle which one Cigar Cigarettes Chewing Tobacco
How often?_____ How long?_____
Have you ever quit?_____

Do you exercise regularly? Yes No

Do you follow a special diet? Yes No

Do you keep a gun at home? Yes No Is it locked?_____

Has anyone at home ever hit or injured you? Yes No

Are you sexually active? Yes No

Do you practice “safe sex”? Yes No

Have you had any blood transfusions? Yes No When?_____

MOUNTAIN VIEW MEDICAL ASSOCIATES
HEALTH ASSESSMENT (continued)

Patient Name__________________________

Date_______________

During the past year:

Has there been a significant increase in the number of days you feel sad or "down"? Yes No

Have you lost interest in activities you used to enjoy? Yes No

Have you had more difficulty with sleep? Yes No

Have you felt you should cut down on drinking? Yes No

Have other criticized your drinking? Yes No

Have you felt guilty about drinking? Yes No

Have you had a morning drink to steady your nerves? Yes No

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	Muscle Cramps	Difficulty Swallowing
Hay Fever	Heat/Cold Tolerance	Weakness	Sinus Problems
Frequent urination	Leaking of urine	Excessive thirst	Shortness of Breath
Excessive fatigue	Palpitations/chest pain	Difficulty sleeping	Bruising or bleeding

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

For each question below, enter the number to the right of the question that best fits your feelings. Use the scale to the right to match your opinions

Stop Smoking? ________

Change Diet? ________

Lose Weight? ________

Exercise? ________

Reduce Stress? ________

Change Alcohol Intake? ________

1- Already made change
2- Ready to make change
3- No opinion/Don't know
4- Not Ready/Want change
5- Not Ready/Don't want change