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

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>Parents</th>
<th>Siblings</th>
<th>Self</th>
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<tbody>
<tr>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Thyroid Problems</td>
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<td>Anemia</td>
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<td>Diabetes</td>
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<td>Stroke</td>
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<td>Cancer</td>
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<td>Tuberculosis</td>
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<td>Asthma</td>
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<td>Lung Disease</td>
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<td>Kidney Stones</td>
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<td>Drug Problems</td>
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<td>Alcoholism</td>
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<tr>
<td>Mental Illness</td>
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RISK ASSESSMENT:
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?____
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)

<table>
<thead>
<tr>
<th>Weight Gain/Loss</th>
<th>Change in Bowel Habits</th>
<th>Jaundice</th>
<th>Change in a mole</th>
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</thead>
<tbody>
<tr>
<td>Indigestion</td>
<td>Joint Pain</td>
<td>Skin Problems</td>
<td>Blood in Stool</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Vision Problems</td>
<td>Muscle Cramps</td>
<td>Difficulty Swallowing</td>
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<td>Hay Fever</td>
<td>Heat/Cold Tolerance</td>
<td>Weakness</td>
<td>Sinus Problems</td>
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<tr>
<td>Frequent urination</td>
<td>Leaking of urine</td>
<td>Excessive thirst</td>
<td>Shortness of Breath</td>
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<tr>
<td>Excessive fatigue</td>
<td>Palpitations/chest pain</td>
<td>Difficulty sleeping</td>
<td>Bruising or bleeding</td>
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If needed, what lifestyle 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? ________ 1- Already made change

Change Diet? ________ 2- Ready to make change

Lose Weight? ________ 3- No opinion/Don’t know

Exercise? ________ 4- Not Ready/Want change

Reduce Stress? ________ 5- Not Ready/Don’t want change

Change Alcohol Intake? ________