

MOUNTAIN VALLEY MEDICAL CLINIC
New Patient Intake Form

Name: _____

Date of Birth: _____ Date of Visit: _____

Welcome to Mountain Valley Medical Clinic! In order to better serve your healthcare needs we are asking you to spend 20 minutes of your time before your visit providing us with your history. This personal history is all about you and will be kept in strict confidence. With this tool, we will have more time to explore the issues you have identified during your visit. We do not want to miss anything important to you.

Thank you,

The Providers at MVMC.

ALLERGIES:

Environmental (hay, food, smoke, etc.) _____

Medication allergies: _____

Past Medical History (other illnesses): _____

Do you now or have you ever smoked cigarettes? Yes _____ No _____.

If yes, how much? _____ How long? _____

SURGICAL HISTORY: (Please list surgeries and approximate dates.)

FAMILY HISTORY:

Mother: Age _____ Alive? _____ Major illnesses: _____

Mother's Parents:

 Mother: Age _____ Alive? _____ Major illnesses: _____

 Father: Age _____ Alive? _____ Major illnesses: _____

Father: Age _____ Alive? _____ Major illnesses: _____

Father's Parents:

 Mother: Age _____ Alive? _____ Major illnesses: _____

 Father: Age _____ Alive? _____ Major illnesses: _____

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Siblings (ages, health status, problems):

Children (ages, health status, problems):

Any other relatives have any of the following?

High blood pressure _____

Heart disease _____

Stroke _____

Cancer _____

Glaucoma or blindness _____

Seizures _____

Headaches _____

Alcoholism _____

Depression or anxiety _____

Learning disabilities _____

Asthma _____

Allergies _____

Other _____

We will discuss all of these answers, but if you would like to comment or elaborate on any of the previous answers, please do so below:

Comments: _____

MEDICATIONS:

Do you take any prescription medications? If yes, please list with dose and how often taken.

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Do you taken any "over-the-counter" medications on a daily or weekly basis? (Examples include Advil, Aleve, aspirin, Pepcid, M.O.M. etc.) If so, please list:

Do you now take or have you taken alternative "self medication" in the last year?

Marijuana? _____

Alcohol (more than three drinks a day)? _____

Diet pills? _____

Cocaine? _____

Other? _____

REPRODUCTIVE HISTORY:

Woman:

Age of first period _____

Age of last period _____

Are periods a problem? _____

of days between periods _____

of days of flow _____

of pregnancies _____

of children born _____

of children lost _____

Men:

of times a father _____

of children _____

Problems with erection? Y or N

Have you ever had a sexually transmitted disease? Y or N

Have you had a lot of different partners? Y or N

Have you had sex with both genders? Y or N

Type of contraception you are currently using:

None _____ Birth control pills _____ Depo Provera shot _____ IUD _____ Diaphragm _____

Condoms _____ Tubes tied _____ Vasectomy _____ Rhythm _____ Other _____

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DIET HISTORY:

Present weight: _____ Desired weight: _____ Highest weight _____ Lowest weight _____

Approximately how many times do you eat the following foods?

Red meat (beef, pork, lamp) _____	Whole grains (whole-wheat bread, brown rice, bran) _____
Chicken, turkey, fish _____	Refined grains (white bread, spaghetti, noodles) _____
Nuts, beans, oils _____	Cakes, candy, ice cream _____
Milk, cheese, yogurt _____	Potato chips, nachos, fried foods _____
Eggs _____	
Fruit _____	
Vegetables, raw _____	
cooked _____	

Do you take vitamins? Please list:

Do you drink coffee? Y or N	Decaf or Caffeinated?	Cups per day? _____
Do you drink water? Y or N	Glasses per day? _____	
Do you drink soda? Y or N	Glasses per day? _____	
Do you drink tea? Y or N	Decaf or Caffeinated?	Cups per day? _____

Have you ever tried to lose weight by taking laxatives, pills or vomiting? Y or N

Do you think you have a problem with food or an eating problem? Y or N

TOXIC EXPOSURE:

Do you have knowledge of a time when you were exposed to toxic substances such as asbestos, chemicals, radiation, excessive noise levels, or other? _____

If yes, please explain. _____

REVIEW OF SYSTEMS

STOMACH and INTESTINES:

CURRENT: In the past year, have you:

1. Had frequent episodes of vomiting? Y or N
2. Vomited blood or a brown material like coffee grounds? Y or N
3. Had persistent constipation requiring frequent laxatives or enema? Y or N
4. Frequently had more than 3 loose bowel movements a day? Y or N
5. Had bloody or black bowel movements or other change in bowel movements? Y or N
6. Had persistent trouble with gas, heartburn, sour stomach, bloating, indigestion, or abdominal pain? Y or N
7. Had recurrent rectal itch, burning or pain? Y or N

PAST: Have you ever had:

8. Stomach or duodenal ulcers? Y or N
9. Hiatus hernia? Y or N
10. Cirrhosis or enlarged liver? Y or N
11. Diverticulitis? Y or N
12. Gallstones? Y or N
13. Pancreatitis? Y or N
14. Polyp or tumor in bowel or rectum? Y or N
15. Other stomach or bowels problems? Y or N

POTENTIAL:

16. Any family history of rectal polyps or cancer of the large bowel? Y or N

KIDNEY/BLADDER/GENITAL

CURRENT: In the past year have you

1. Had painful burning when urinating that lasted several days? Y or N
2. Had bloody urine? Y or N
3. Had trouble starting to urinate? Y or N
4. Been troubled by leaking of urine? Y or N
5. Had to get up at night more than once to urinate? Y or N
6. MEN ONLY: (Woman go to question #7)
 - a. Had discharge from penis? Y or N
 - b. Had prostate trouble? Y or N
 - c. Felt you area losing your sex drive or potency more than you think normal? Y or N
 - d. Any other problems with sexual function? Y or N

PAST: Have you ever:

7. Had an infection in the kidney or bladder in the last five years? Y or N
8. Had a kidney stone? Y or N
9. Had other serious kidney/bladder problem? Y or N

SKIN:

CURRENT: In the past year have you had:

1. Troublesome acne? Y or N
2. Persistent or recurrent skin problems? Y or N
3. Mole(s) that changed in size or color? Y or N
4. Used medication for any skin problems regularly? Y or N

PAST: Have you ever had:

5. Skin cancer? Y or N
6. Psoriasis? Y or N
7. Other serious skin problems? Y or N

BREASTS:

CURRENT: In the past year have you had:

1. Lumps or unusual soreness in your breasts or nipples? Y or N
2. Discharge from your nipples? Y or N

PAST: Have you ever had:

3. A breast operation or biopsy? Y or N
4. A mammogram? If so, when? Y or N _____
5. Other serious breast problems? Y or N

POTENTIAL:

6. Family history of breast cancer? Y or N

MUSCLES/JOINTS/BONES:

CURRENT: In the past year have you had:

1. Had neck or back stiffness or pain which interfered with your normal activities for more than several days? Y or N
2. Had troublesome joint stiffness, pain or swelling? Y or N
3. Needed help with daily activities because of weak muscles? Y or N

PAST: Have you ever had:

4. Gout? Y or N
5. Other serious or disabling problems with your bones, joints or muscles? Y or N

NERVOUS SYSTEM:

CURRENT: In the past year have you had:

1. Recurring severe headaches? Y or N
2. Troublesome dizzy spells? Y or N
3. Temporarily (minutes to hours) lost the use of an arm, hand, leg, sight or speech? Y or N
4. Blackout spells (loss of consciousness)? Y or N
5. Serious trouble with memory or coordination? Y or N
6. Persistent shaking of the hands? Y or N
7. Trouble with falling? Y or N

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SAFETY:

Do you use a safety belt when in a motor vehicle? Y or N

Do you have a gun in the house? Y or N

Do you drink alcohol and drive? Y or N

ACTIVITY:

Do you think you get enough exercise? Y or N

What do you like to do for physical activity? (Examples: Walk, clean, swim, run, sport, yoga, etc.)

Do you like who you are? _____

Do you want to make a change in your life? _____

What did you want to be when you were little? _____

Do you feel loved? _____

I understand that my examination may not be paid for by my insurance carrier. I accept the financial responsibility for payment if applicable.

Signature _____ Date _____