Mtn Medical

*"Health care you deserve!"*

NEW PATIENT Request

# PLEASE INDICATE IF YOU ARE TAKING ANY NARCOTICS

**_____YES**

**_____NO**

*****WE DO NOT PRESCRIBE THE FOLLOWING*****
Clozipine, Ativan, Lorazepam, Clonazepam, Xanax, Lortab, Hydrocodone, Norco, Tramadol, Methadone, Oxycodone, Tylenol # 3 or 4, Oxycontin, Oxymorphone, Suboxone, Subtex, Adderall, Amphetamine Salt, Concerta, Vyvanse, or Ritalin

## Personal History

Today's Date: _____ Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ Patient Phone#_____
City: _____ State: _____ Zip:_____ Gender: Male_____ Female_____
Primary Care Physician:_____
Reason for Leaving: _____
_____

## Insurance Details

Please sign if you are a self-pay patient (no insurance): _____

**Primary Insurance Company**:_____ **Secondary InsuranceCompany**:_____

| **Current Medications** (including over the counter medication) | Reason for Medication Use |
|---|---|
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| | |

## Social History

Tobacco Usage: Yes_____ No_____ # of Packs / Cans per day: _____For How Many Years: ___
Alcohol Beverages: Yes_____ No_____ # of Drinks per week: _____For How Many Years: ___
Recreational drug use: Yes_____ No_____
Caffeinated Beverages: Yes_____ No_____ # of Drinks per day:_____
Number of Children in Home: _____ Are you afraid of anyone at home: Yes____ No_____
Do you have guns at home: Yes_____ No_____ If guns at home are they locked up: Yes____ No_____
Athletic Interests / Hobbies: _____ How did you hear about us:_____
_____ _____

## Surgeries / Other Hospitalizations

| Year | Operation | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Allergies** (Medication / Food / Other): | Reaction: |
|---|---|
| | |
| | |
| | |
| | |

## Family History

| Please check all that apply | To You | Family Member | Please check all that apply | To You | Family Member |
|---|---|---|---|---|---|
| Alcoholism | | | Mental Illness | | |
| Arthritis | | | Migraine | | |
| Asthma | | | Obesity | | |
| Breast Cancer | | | Osteoporosis | | |
| Colon Cancer | | | Ovarian Cancer | | |
| Diabetes | | | Prostate Cancer | | |
| Glaucoma | | | Stroke | | |
| Hay Fever | | | Ulcer Disease | | |
| Heart Disease | | | Drug Abuse | | |
| High Blood Pressure | | | Other Cancer, please specify: _____ _____ | | |
| High Cholesterol | | | Other:_____ _____ | | |
| Liver Disease | | | | | |

If you checked any of the boxes above please list the person/s that it applies, your relations, and diagnosis below:

## Women Only

Number of pregnancies: _____ Number of deliveries: vaginal_____ C-section_____
Date of last period: _____ Frequency of periods: _____
Birth control method: _____ Date of last pap smear: _____
Self-breast exam: Yes _____No_____ Date of last mammogram: _____
Number of miscarriages: _____ Number of terminations: _____

## Immunizations

| Type of Immunization | Date | Other Immunizations | Date |
|---|---|---|---|
| Last Pneumonia | | | |
| Last Tetanus | | | |
| Last Influenza | | | |
| Last TB Skin Test | | | |

If under the age of 18, are immunizations current: YES_____ NO_____