HIGH MOUNTAIN HEALTH

HIGH MOUNTAIN HEALTH, P.A.
Patient Health History

Living Will Yes ___ No ___ **Organ Donation** Yes ___ No ___

Family History

	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
Heart Disease						
High Bld Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilespy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental illness						
Other						

Hospitalizations or Surgery

Reason	Date	Reason	Date
Pregnancy	Yes No	Planning Pregnancy	Yes No

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Past Medical History

Headache	Gall bladder disease	Chronic Rashes
Shortness of Breath	Prostate disease	Rheumatic Fever
Heart palpitations	Bowel irregularity	Last Tetanus shot
Heart murmur	Sexual menstrual dysfunction	Last MMR shot
Chest pain	Venereal disease	GI disorder
Dizziness/Fainting	Frequent infections	Ulcer
Peripheral vascular disease	Hepatitis	Gout
Allergies/Hay fever	Anemia	
Asthma	Arthritis	
Bronchitis	Scarlet fever	
Pneumonia	Depression	

Personal Habits

Smoke: Yes No Packs daily:_______ How Long:__________

Exercise routine: ____________________ Coffee: Cups daily _________
Other Caffeine:_____________

Alcohol: Type/ Amount:_______________ Insomnia: __________________

Diet: Salt intake: _____________________

Contact with blood or body fluid at work:___________________________

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