NORTH VISTA MEDICAL CENTER

Personal History

Name: _____ Date: _____ Phone:_____ DOB:_____

Cell:_____ Sex: M F T

YOUR MEDICAL HISTORY (Please circle which medical conditions you have had):

High Blood Pressure	Liver Disease	Kidney Problems	Other Conditions:
Heart Problems	Stomach Ulcers	Low Back Pain	_____
High Cholesterol	Diverticulitis	Arthritis	_____
Diabetes	Gallstones	Neurologic Problems	_____
Stroke	Pancreatitis	Mental Illness	_____
Lung Problems	Blood Clots	Depression/Anxiety	_____
Asthma	Anemia	Cancer (type of cancer)	_____
Allergies	Thyroid	_____	_____

Your Surgeries / Operations:

_____

Your Current Medications:

_____

Allergies to Medications:

_____

How often do you use tobacco? _____Occupation:_____Pets:_____
Drinks per week?_____ Marital Status: _____Hobbies:_____
Any Recreational drug use?_____ Ages of Children: _____ Do you exercise?_____

Your Family History (Do you have any blood relatives with these problems?):
Heart Attack (who and what age?)_____
Cancer (who and what age?) _____
Other: _____
Have you or anyone in your family ever been threatened, injured or abused by someone you know?_____

Vaccinations / Immunizations (Date of last shot):
Flu Shot (influenza):_____Pneumonia Shot (pneumovax):_____
Hepatitis B: _____ Chicken Pox (Varivax):_____ Tetanus:_____

Preventative Health Maintenance (Please indicate year of last screening – if applicable):
Mammogram / PSA: _____Colonoscopy: _____
PAP Smear: _____Cholesterol Exam: _____
Bone Density / Dexa Scan: _____ Eye Exam: _____

Please tell us if you have any specific goals for your health, wellness and medical care?

_____

Are there any other important things we should know about you?

_____

How did you hear about North Vista Medical Center? _____