

HIGH MOUNTAIN HEALTH, P.A. Patient Health History

Do you have a Living Will? Yes No Organ Donation Yes No

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorders						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Other						
History of Hospitalizations or Surgery						
Reason	Date		Reason	Date		

Are you pregnant? Yes No Are you planning a pregnancy? Yes No

When was your last Tetanus shot? _____ Last MMR shot? _____

Your Past Medical History – Circle any that apply		
Headaches	Gall bladder disease	Chronic Rashes
Shortness of Breath	Prostate disease	Rheumatic Fever
Heart palpitation	Bowel irregularity	GI disorder
Heart murmur	Menstrual dysfunction	Ulcers
Chest pain	Venereal disease (STDs)	Hepatitis
Dizziness or Fainting	Frequent infections	Gout
Peripheral vascular disease	Anemia	Asthma
Allergies/Hay fever	Arthritis	Bronchitis
Scarlet fever	Pneumonia	Depression
Insomnia		



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Do you smoke? Yes No If "Yes," how long have you smoked? _____

How much do you smoke? Packs per day

Do you have an exercise routine? If "Yes," describe your routine and indicate how many days per week you exercise _____

Do you drink coffee? Yes No If "Yes," how many cups daily? _____

Do you drink other beverages that contain caffeine? _____

Do you drink alcohol? Type _____. Approximate amount: _____

Do you use salt on a daily basis? Yes No If "Yes," how much? _____

Do you come into contact with blood, blood products or body fluids at work?

Yes No