GEORGIA MOUNTAINS HEALTH

Patient Name:_____

Date of Birth:_____ M____F____ Race:_____

What is the reason for your visit today?_____

_____

_____

Please check conditions which you have had:

- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BACKACHE
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ COPD
- ☐ DEPRESSION
- ☐ DIABETES MELLITUS
- ☐ DIZZINESS
- ☐ EYESIGHT PROBLEMS
- ☐ FAINTING
- ☐ GALLBLADDER DISEASE
- ☐ ULCER
- ☐ GOUT
- ☐ HEADACHE SYNDROME
- ☐ HEARING LOSS
- ☐ CARDIAC MEDICAL HISTORY
- ☐ HEPATITIS
- ☐ HIV INFECTION
- ☐ HYPERTENSION
- ☐ LIVER, STOMACH, OR BOWEL DISEASE
- ☐ LUPUS
- ☐ NON MOVING LIMBS(PARALYSIS)
- ☐ NUMBNESS
- ☐ OSTEOPOROSIS
- ☐ RENAL (KIDNEY) DISEASE
- ☐ RESPIRATORY DISORDERS
- ☐ RHEUMATOID ARTHRITIS
- ☐ SARCOIDOSIS
- ☐ SEIZURES
- ☐ SPINE DISORDERS
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ URINARY TRACT INFECTION
- ☐ STD

Please check any surgeries you have had and the year:

- ☐ _____GENERAL SURGERY
- ☐ _____ENT SURGERY
- ☐ _____CATARACT SURGERY
- ☐ _____THYROID SURGERY
- ☐ _____TONSILLECTOMY
- ☐ _____AORTIC ANEURYSM REPAIR
- ☐ _____ANGIOPLASTY
- ☐ _____CABG
- ☐ _____OTHER HEART SURGERY
- ☐ _____CORONARY ANGIOPLASTY
- ☐ _____MASTECTOMY, OTHER BREAST SURGERY
- ☐ _____ABDOMINAL SURGERY
- ☐ _____APPENDECTOMY
- ☐ _____CHOLECYSTECTOMY
- ☐ _____COLECTOMY, PARTIAL
- ☐ _____GASTROPLASTY, BARIATRIC
- ☐ _____OTHER GASTRIC SURGERY
- ☐ _____HERNIA
- ☐ _____INTESTINAL BYPASS
- ☐ _____OPEN LYSIS ADHESIONS
- ☐ _____SMALL BOWEL RESECTION
- ☐ _____ULCER SURGERY
- ☐ _____SKIN/DERMAL SUGERY
- ☐ _____ORTHOPEDIC SURGERY
- ☐ _____BACK SURGERY
- ☐ _____CARPAL TUNNEL
- ☐ _____NEUROSURGERY
- ☐ _____CESAREAN SECTION
- ☐ _____HYSTERECTOMY
- ☐ _____OOPHORECTOMY
- ☐ _____TUBAL LIGATION
- ☐ _____BLADDER SURGERY
- ☐ _____PROSTATE SURGERY
- ☐ _____TURP
- ☐ _____LITHOTRIPSY
- ☐ _____KIDNEY SURGERY

Please check and date any of the following you have received in the past two years:

☐ ____CARDIAC ANGIOGRAM	☐ ____FLU VACCINE	☐ ____CERVICAL PAP SMEAR
☐ ____CHEST XRAY	☐ ____HEPATITIS B VACCINE	☐ ____MAMMOGRAM
☐ ____STRESS TEST	☐ ____PNEUMONIA VACCINE	☐ ____RECTAL EXAM
☐ ____ECHOCARDIOGRAM	☐ ____TETANUS BOOSTER	☐ ____COLONOSCOPY
☐ ____EKG	☐ ____HPV VACCINE	☐ ____COLON CANCER SCREEN
☐ ____BONE DENSITY TEST	☐ ____ZOSTER VACCINE	☐ ____PROSTATE EXAM

Please list any Allergies or intolerance to drugs or other substances:_____

_____

Please list current Medications, dosages and how many per day:

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

PLEASE CHECK BOX OR LIST ANY MAJOR ILLNESS IN YOUR FAMILY MEMBERS:

	CHILD	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
CANCER						
DIABETES						
HEART DISEASE						
HYPERTENSION						
STROKE						
ARTHRITIS						
LUPUS						
MENTAL ILLNESS						
RHEUMATOID ARTHRITIS						
SARCOIDOSIS						
SEIZURE						
TUBERCULOSIS						

PLEASE CIRCLE ALL THAT APPLIES TO YOU:

EDUCATION	SEXUALITY	MARITAL STATUS	LIVING STATUS	DIET	EXERCISE
Primary	Heterosexual	Single	Alone	None	None
Secondary	Homosexual	Married	With Spouse	Low Fat	Walking
College	Bisexual	Divorced	With Parents	Low Carb	Aerobics
Post Graduate	Transsexual	Widowed	Assisted Living	Low Cholesterol	Weightlifting
Doctorate		Separated	Nursing Home	Vegetarian	___days/week

ALTERNATIVE MEDICINE	TOBACCO	ALCOHOL	DRUGS	CAFFEINE
Never/past/active Holistic Chiropractic Homeopathy Accupuncture Herbal	Never/past/active Cigarettes/cigar/pipe Snuff/dip/chewing Start_____Stop____ Packs per day_____	Never/past/active Liquor/wine/beer _____drinks per day/ Week/month AA/Rehab	Never/past/active Cocaine/Marijuana Heroine/Amphetamine Barbiturate/LSD/PCP IV Drug Abuse NA/Drug Rehab	Never/past/active Coffee/Tea/Soda ___Cans/Cups per day.