New Patient Medical History Form
Rocky Mountain Comprehensive Health
Teresa Heisser, MSN, FNP-C Judy Ponsford, NP-C

Name: First_____ Last _____ Age_____
Date of Birth:_____
Address Street:_____
City:_____ State:_____ Zip:_____
E-Mail Address: _____Occupation:_____
Home Phone Number: _____ How did you hear about us?:_____
Mobile Phone Number: _____
Primary Care Provider_____
What is the primary reason for your office visit today?
_____
When did your symptoms start? _____
What makes your symptoms better or worse? _____
What are your goals for treatment? _____
_____
_____

Current Symptoms/Conditions: (Please circle yes or no for all symptoms)

GEN	**Y**	**N**	Fatigue
	Y	**N**	Fever
	Y	**N**	Chills
	Y	**N**	Weight gain/loss
ENT	**Y**	**N**	Headaches
	Y	**N**	Dizziness, fainting
	Y	**N**	Vision changes
	Y	**N**	Nasal congestion
	Y	**N**	Sore throat
	Y	**N**	Difficulty swallowing
	Y	**N**	Swollen glands
GI	**Y**	**N**	Constipation
	Y	**N**	Diarrhea
	Y	**N**	Bloating/gas
	Y	**N**	Acid Reflux
	Y	**N**	Nausea/vomiting
	Y	**N**	Abdominal pain
	Y	**N**	Black/ bloody stools
RESP	**Y**	**N**	Cough
	Y	**N**	Shortness of breath
HEART	**Y**	**N**	Chest pain
	Y	**N**	Heart palpitations
	Y	**N**	Irregular Heartbeat
GYN	**Y**	**N**	Pelvic pain
	Y	**N**	Vaginal discharge
	Y	**N**	Irregular menstruation
GU	**Y**	**N**	Bladder infections
	Y	**N**	Blood in urine
	Y	**N**	Urinary urgency
	Y	**N**	Urinary Frequency
	Y	**N**	Waking to urinate
	Y	**N**	Incontinence
SKIN	**Y**	**N**	Nail changes
	Y	**N**	Acne
	Y	**N**	Skin dryness
	Y	**N**	Rashes
	Y	**N**	Bruises easily
MS	**Y**	**N**	Muscle aches
	Y	**N**	Joint pain
	Y	**N**	Swelling in extremities
MOOD	**Y**	**N**	Anxiety
	Y	**N**	Depression
	Y	**N**	Irritability
NEURO	**Y**	**N**	Numbness/tingling
	Y	**N**	Weakness

Hormonal Symptoms: (Please check all symptoms that apply)

- ○ Irregular menstrual bleeding
- ○ Hot flashes
- ○ Night sweats
- ○ Absence of menstruation
- ○ Painful intercourse
- ○ Vaginal Dryness
- ○ Poor memory
- ○ Irritability
- ○ Mood changes
- ○ Tearfulness
- ○ Insomnia/waking often
- ○ Early waking
- ○ No motivations
- ○ Low libido
- ○ Urinary symptoms
- ○ Breast tenderness
- ○ Migraines
- ○ Fibrocystic breasts
- ○ PMS
- ○ Menstrual cramps
- ○ Heavy menstrual bleeding
- ○ Bloating
- ○ Increased body hair
- ○ Acne
- ○ Thinning hair/hair loss
- ○ Weight gain
- ○ Fatigue
- ○ Dry skin/hair
- ○ Puffy hands/face
- ○ Cold hands/feet
- ○ Constipation
- ○ Muscle/joint pain
- ○ Low mood
- ○ Heart Palpitations
- ○ Feeling shaky
- ○ Low blood pressure
- ○ Low blood sugar
- ○ Feeling "wired but tired"

Sleep:

How many hours of sleep do you get each night? _____ hours
Do you have trouble falling asleep? Yes No Staying asleep? Yes No Wake often? Yes No
Do you wake refreshed? Yes No

Personal Past Medical History: (Please check all that apply and include date diagnosed)

- ○ Kidney Disease
- ○ High blood pressure
- ○ Stomach problems
- ○ Autoimmune disease
- ○ Depression
- ○ Hormone problems
- ○ Respiratory problems
- ○ Breast problems
- ○ High cholesterol
- ○ Thyroid disorders
- ○ Cancer or tumors
- ○ Migraines
- ○ Tuberculosis
- ○ Blood disorder
- ○ Osteoporosis
- ○ Arthritis
- ○ Diabetes
- ○ Heartburn
- ○ Fibroids
- ○ Anxiety
- ○ Stress
- ○ Other _____
  _____

Family History:
Please list which family member(s) and type(s) of diseases:

Thyroid disease_____

Heart disease/High Blood Pressure
_____

Stroke _____

High cholesterol_____

Kidney disease _____

Osteoporosis _____

Cancer _____

Diabetes _____

Blood/clotting disorder _____

Other _____

Surgical History: (Please list all surgeries that you have had since birth and indicate the year it was performed)

_____
_____
_____
Hospitalizations: _____
Injuries: (please include the year)_____

Allergies to medications/foods/other:_____
Medications: (please list dosage if possible)_____
_____
_____
_____

Supplements/Vitamins/OTCs: _____
_____
_____

Social History:
Do you drink alchohol? Yes No If so, how often? _____
Do you exercise? Yes No If so, how often? _____
What is your marital status? Single Married Divorced Widowed
Do you drink coffee or caffeinated drinks? Yes No If yes, how many cups per day? _____
Tobacco Use:
Cigarettes ___ Never or Quit Date _____ Current Smoker: packs/day & # of yrs _____
Is there any other health related issue you can share that might impact your health? Yes No
If Yes, explain:_____

Diet:
Do you struggle with sugar cravings? Yes No
Are you on any dietary restrictions? (i.e. gluten-free, vegetarian, vegan?) _____

Do you regularly eat/drink any other the following? (Circle all that apply) Bread Pasta Cookies Chocolate Vegetables Fruit Cheese Dairy Fish Corn Soda Fruit Juice Soy Chips Crackers Rice Desserts

Technology/Screen Time: How many hours a day do you:
Type/use a computer? _____ Watch TV? _____ Play video games?_____ Spend on Facebook?_____
Text?_____ Do you bring the computer or phone to bed? Yes No Do you fall asleep with the TV on? Yes No

Mood/Stress Management:
Are you experiencing a chronic low mood? Yes No Do you feel anxious or nervous? Yes No
In the past month, have you had little motivation or pleasure in doing things? Yes No
Do you have activities in your life that bring you joy? Yes No
How would you rate your current level of stress? Mild Moderate Severe
How would you rate your family/social support? Poor Fair Good Strong
What activities or routines help you to "de-stress?" _____

Health Maintenance Screening Tests: (List most recent date)
Physical exam Yes No Date _____ Abnormal? Yes No
Cholesterol test Yes No Date _____ Abnormal? Yes No
Sigmoidoscopy or Colonoscopy: Yes No Date _____ Abnormal? Yes No
Women: Mammogram: Yes No Date _____ Abnormal? Yes No
Women: pap smear: Yes No Date _____ Abnormal? Yes No
Bone Scan: Yes No Date _____ Abnormal? Yes No

Women Only:
First Day of most recent menstrual Cycle: _____ Age first started period: _____
How long do your cycles last? _____
Are your periods regular? Yes No
Do you miss your period or have more than one per month? Yes No
Do you experience any heavy bleeding? Yes No
Do you have a history of infertility? Yes No
Are you on birth control? Yes No If yes what method? _____
How many children do you have? (Circle one) 1 2 3 4 5 more than 5
Have you ever had a miscarriage? Yes No If so, how many? _____
Have you started menopause? Yes No If so, when was the onset? _____
Are you pregnant? Yes No

Men Only:
Do you have a history of prostate disease/enlargement/cancer? Yes No
Have you ever had an elevated PSA? Yes No
Do you have any symptoms of Erectile Dysfunction? Yes No

Do you wake more than once at night to urinate? Yes No

Do you have urinary frequency/ urgency? Yes No

Have you had any recent loss of muscle mass or weight gain? Yes No