MOUNTAIN VIEW SPECIALTY CLINIC

HIGHWAY 14 EAST/P.O. BOX 1580
MOUNTAIN VIEW, AR 72560

Thank you for visiting our clinic. Please print the following information to help us serve you better.

PATIENT INFORMATION: **R**eason for Visit: ________________________________R___L___

Legal Name: ____
Last First Middle Maiden

SS# ______-______-________ Male ___ Female___ Date of Birth ____/____/______ Age _____

Address ____ City ___________________ State____ Zip ________

Home Phone ( )______________ Work Phone ( )________________ Marital Status ______________

Occupation _________________________ Employer _________________________

REFERRING PHYSICIAN: Name _________________________________ City ____________________

FAMILY OR PRIMARY CARE PHYSICIAN (PCP) ___Same as Referring Physician

Name ____ City____________________________

INSURANCE: Do you have medical insurance? Yes ____ No ____

If you do not have insurance, how do you plan to pay for services today? Cash, Check, or Credit Card

in full today ____, Workman's Comp ____, Payment Plan ____, Other ____

If this visit is related to an accident or Worker's Compensation, please provide the following:

Type of Accident/Injury: Auto ____ Crime ____ Employment ____ Other ____
Date of Accident/Injury: _______________ Place of Accident/Injury: ______________________
Is this Worker's Comp? Yes ____ No ____ If yes, list contact name ________________________
Phone # ( ) _________________

Height ________ Weight ______

MEDICAL HISTORY:
Have you had or still have any of the following:

Meningitis	___ YES	___ NO	Arthritis	___ YES	___ NO
Infectious Mononucleosis	___ YES	___ NO	High Blood Pressure	___ YES	___ NO
Tuberculosis	___ YES	___ NO	Heart disease	___ YES	___ NO
Exposure to TB	___ YES	___ NO	Anemia	___ YES	___ NO
Bronchitis	___ YES	___ NO	Bleeding tendency	___ YES	___ NO
Pneumonia	___ YES	___ NO	Ulcer	___ YES	___ NO
Hepatitis (yellow jaundice)	___ YES	___ NO	Cancer	___ YES	___ NO
Bladder Infections	___ YES	___ NO	Blood transfusion	___ YES	___ NO
Rheumatic fever	___ YES	___ NO	Diabetes	___ YES	___ NO
Kidney disease	___ YES	___ NO	Other (list) ______________________________		
Asthma	___ YES	___ NO	______________________________		
Emphysema	___ YES	___ NO	______________________________		

SURGICAL HISTORY: Yes ____ No ____

Please List	Year
____	________
____	________
____	________

Have you or a close family member ever had problems with anesthesia? Yes____ No____
If yes, please describe: ____

ALLERGIES: Yes ____ No ____

List all drugs or substances to which you are allergic and specify the type of reaction: itching, rash, hives, wheezing, swelling, difficulty breathing, etc.

Drug/Substance	Reaction
____________________________________	_____________________________
____________________________________	_____________________________

MEDICATIONS: Yes ____ No ____ If you have a list, please give it to the receptionist!

List all medications which you now take regularly to include diet supplements/vitamins and herbal preparations.

Medication	Strength	Times per day
_______________________________	_______	__________
_______________________________	_______	__________
_______________________________	_______	__________
_______________________________	_______	__________
_______________________________	_______	__________

Remarks: ____
____

FAMILY HISTORY:
Has any blood relative had any of the following:

Condition	Yes	No	Condition	Yes	No
Crippling arthritis	___ YES	___ NO	Convulsions or seizures	___ YES	___ NO
Chronic lung disease	___ YES	___ NO	Heart disease	___ YES	___ NO
High blood pressure	___ YES	___ NO	Diabetes	___ YES	___ NO
Kidney disease	___ YES	___ NO	Gout	___ YES	___ NO
Asthma	___ YES	___ NO	Obesity	___ YES	___ NO
Severe allergies	___ YES	___ NO	Cancer	___ YES	___ NO
Mental illness	___ YES	___ NO	Others	_______________________________	

If yes, what relationship: _______________________________
____

SOCIAL HISTORY:

Alcohol Use	Tobacco Use	Illicit Drug Use
___ 1-2 drinks/day	# of years ___	Yes ___
___ 1-2 drinks/week	Packs/day ___	No ___
___ 3 or more/day		
___ Rarely Drinks		

Release and Assignment:

1. I authorize the release of any medical information necessary to process my insurance claims.

2. I authorize and request payment of medical benefits directly to my physicians.

3. I agree that this authorization will cover all medical services rendered until revoked by me.

4. I understand that I am responsible for **all insurance deductibles and amounts not otherwise covered by my insurance.**

5. **Payment is expected at time of service unless other arrangements are made.**

By typing your name below you are agreeing to the above conditions.

______________________________________ _______________

Typed by Patient or Guardian Date

Reviewed By: ___________________ Date: _______________

CHECKLIST: Review of Systems

Checklist:

General-

__ Weight loss or gain   __ Fever or chills
__ Fatigue   __ Weakness

Skin-

__ Rashes   __ Itching
__ Lumps   __ Dryness

Head-

__ Headache   __ Head Injury

Ears-

__ Decreased hearing   __ Earache
__ Ringing in ears (tinnitus)   __ Drainage

Eyes-

__ Vision changes   __ Glasses or contacts
__ Pain   __ Redness

Nose-

__ Stuffiness   __ Itching
__ Discharge   __ Nosebleeds

Throat-

__ Bleeding   __ Dry mouth
__ Sore throat   __ Teeth

Neck-

__ Lumps   __ Pain
__ Swollen glands   __ Stiffness

Breasts-

__ Lumps   __ Discharge
__ Pain   __ Breast-feeding

Respiratory-

__ Cough (dry or wet, productive)   __ Wheezing
__ Shortness of breath (dyspnea)   __ Painful breathing

Cardiovascular-

__ Chest pain or discomfort   __ Tightness
__ Palpitations   __ Shortness of breath with activity (dyspnea)

Gastrointestinal-

__ Nausea   __ Vomiting
__ Constipation   __ Diarrhea

Urinary-

__ Frequency	__ Urgency
__ Burning or pain	__ Blood in urine (hematuria)

Vascular-

__ Calf pain with walking (Claudication)	__ Leg cramping

Musculoskeletal-

__ Muscle or joint pain	__ Swelling of joints
__ Stiffness	__ Redness of joints

Neurologic-

__ Dizziness	__ Weakness
__ Fainting	__ Seizures

Hematologic-

__ Ease of bruising	__ Ease of bleeding

Endocrine-

__ Heat or cold intolerance	__ Frequent urination (polyuria)
__ Sweating	__ Thirst (polydypsia)

Psychiatric-

__ Nervousness	__ Memory loss
__ Depression	__ Stress