Full Name: ______________________________

MOUNTAIN VIEW HOSPITAL REDICARE
OPTIMAL HEALTH PATIENT INTAKE FORM

First Name: ______________________ **Middle Initial:** ________

Last Name: ______________________ **E-Mail:** ______________________

Gender: [ ] F [ ] M DOB:____________ **Age:** ____________

The following questions will assist your health provider in helping you reach your individual health goals. Please answer each question completely and to the best of your ability. If you do not understand a question, please indicate with a question mark (?). If the question does not apply to you, please indicate with (N/A). Your health provider will analyze this information, and together with your physical examination and assessment, they will design a personalized health optimization program for you. This questionnaire is part of your medical record and will be held in the strictest confidence.

Please tell us all of your ***Health Goals***, the ***Purpose of Your Consultation*** and your ***Desired Results*** from our program:

Please list any ***current health related complaints or concerns*** (please list your top four):

Full Name: ____

MEDICAL HISTORY

Please indicate any ***medical problems*** that you are currently seeing a medical professional for and the age you were first diagnosed with the condition. Please attach a separate sheet of paper if needed. If they are a repeat from the question above, please state, "See Above":

Please specify any ***Surgical Procedures*** you have had in the past:

Please list all of your current ***Medication*** prescribed by a health care professional:

Drug Name	Dosage Used	Times of Day Taken	Who Prescribed it?

Please list all of your current ***Supplements*** (nutritional/herbal/vitamins/minerals/etc.):

Supplement Name	Amount Used	Times of Day Taken	Who Prescribed It?

Full Name: ____

Please list all ***Drug Allergies:***

Are you concerned with your hormonal health? ________If yes, please list the symptoms you are having that are hormone related:

FAMILY HISTORY

Please indicate any ***Family Medical History***. Please include age of onset and death if applicable:

Mother	Father	Siblings	Children

SOCIAL HISTORY

Do you smoke? [ ]Y [ ]N
If yes: _______ Cigarettes/day
_______ Cigars/day
________ Number of Years

Do you drink alcohol? [ ]Y [ ]N
If yes: ___________ beers/day
___________ glasses of wine/day
___________ mixed drinks/day

Do you use other tobacco? [ ]Y [ ]N
If yes: ________ snuff
________ chewing tobacco
________ number of years

Do you have a good support system for your optimal health program? If yes, who?

Full Name: ____

LIFESTYLE AND BEHAVIORAL HISTORY

Please list any/all ***Diets*** you have been on or attempted in the past. Please indicate how you did on each of these diets (use reverse side if necessary):

Please indicate any/all ***Exercise Programs*** you have done in the past, or are currently doing, and how did you do on each program?

What exercise modalities do you have available today?

Full Name: ____

GENERAL EARLY DETECTION

The following is a list of ***Early Detection Procedures***. Please indicate if you have had the procedure, when you had the procedure, and the result of that procedure:

Exercise Stress Test:____

EKG:____

Cholesterol/Lipid Studies:____

Chest X-Ray: ____

Blood Test for Infectious Disease (HIV/TB/Hepatitis B and C/etc.):
____

Colon Studies:____

Blood Sugar Tests: ____

Dental and Oral Exam: ____

Skin Exam:____

Immunizations: ____

MALE

PSA: ____

Prostate Exam: ____

FEMALE

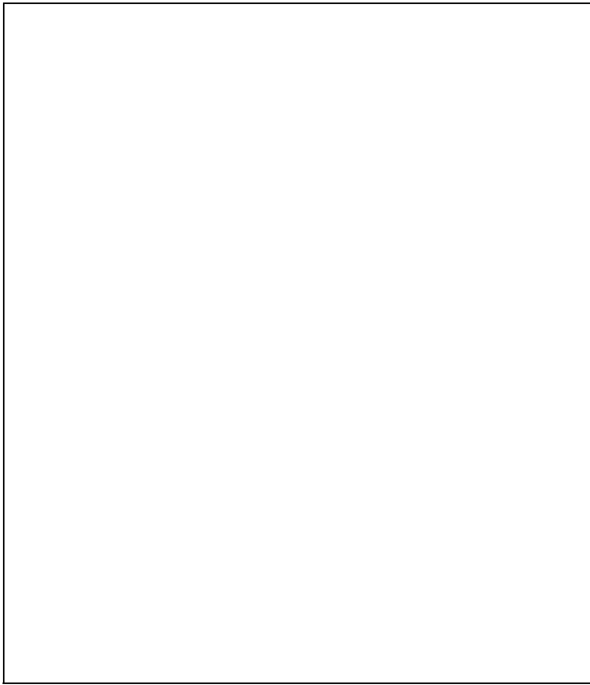
Mammogram: ____

PAP Smear: ____

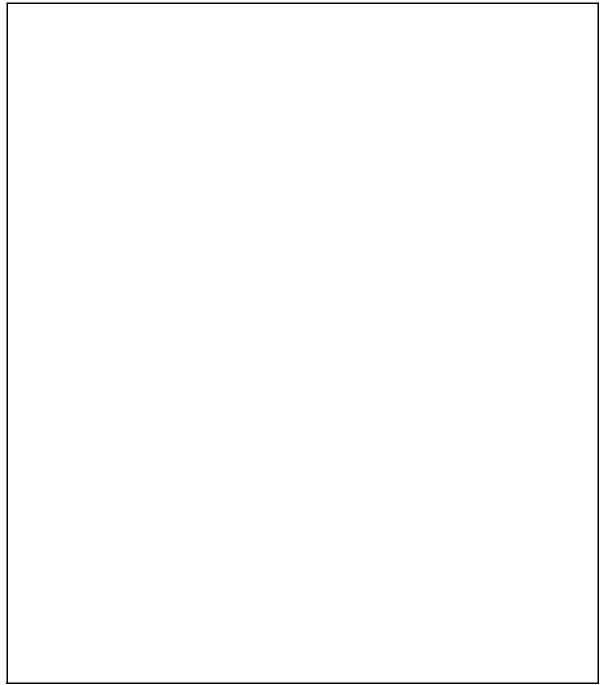
Full Name: ______________________________

FOOD QUESTIONNAIRE

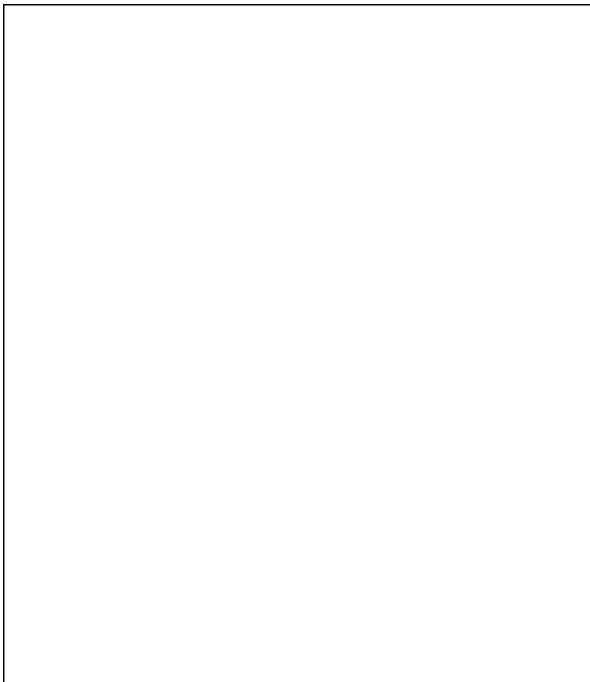
15 Most Common or Favorite Foods



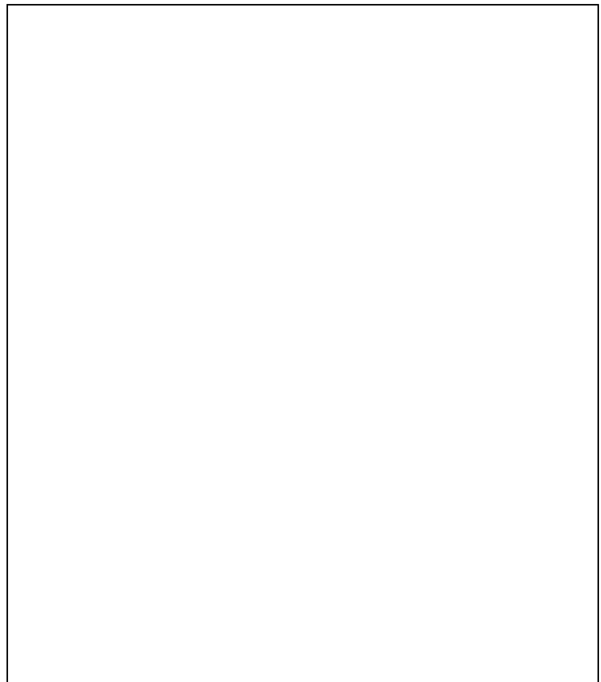
Average Daily Diet (with times)



Average Daily Schedule (with times)



Foods You Do Not Like



Full Name: ______________________________

INVENTORY OF FOODS AND BEVERAGES YOU USUALLY CONSUME

Please indicate the approximate number of times per week you eat the following:

Meats/Poultry/Fish/Pork: ______________________________

Carbohydrates (Breads/Cereals/Potato based products):

____

Vegetables and Fruits: ______________________________

Desserts/Sweets: ______________________________

Nuts and Seeds: ______________________________

SLEEP HISTORY/INVENTORY

Usual Bedtime: ______________________________

Average # of Hours Slept/Night: ______________________________

Do You Have Difficulty Falling Asleep: ______________________________

How Do You Feel Upon Awakening? ______________________________

Do You Get Up At Night to Empty Your Bladder? ______________________________

Do You Have Problems Falling Back Asleep? ______________________________

Do You Use Any Sleep Medication? ______________________________

Has anyone told you that you stop breathing at night?______________________________

Do You Snore? ______________________________

Other Sleep Problems/Concerns? ______________________________

Full Name: ____

STRESS HISTORY/INVENTORY

On a scale of 1-10, 1 being no stress and 10 being the worst stress imaginable, what is your overall stress rating? ____________________

What are the sources of your stress?

What do you do to relax and relieve stress?

What is your response to stress and frustration?