MAMMOTH HOSPITAL
Elevate Your Health

Please bring the following items to your appointment:

- Medication bottles, including vitamins (or an updated list including the dose, and how often you take it.)
- Glasses or Contacts
- Hearing aids
- Walking aids
- Past medical information *(if being seen in Family Medicine for the first time)*

If you have any questions about this form, or your upcoming appointment, please do not hesitate to contact our office using the patient portal or by phone. (760) 934-2551

Appointment date: _____/_____/_____

Check in time:_____

Return this form to the clinic by: _____/_____/_____

Please return this form to the address below

Mammoth Hospital - Family Medicine Clinic
85 Sierra Park Road
P.O. Box 660
Mammoth Lakes, CA 93546

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Name:	Date of Birth:	Today's Date:
*Last:*_____ *First:*_____ *Middle:*_____	*MM/DD/YYYY* ____/___/____	*MM/DD/YYYY* ____/___/____

Other Physicians And Providers of Care

Name:	Why Are you seeing this doctor?

Immunizations: If you do not know the exact date, **please gather and bring this information with you to the appointment.**

Hepatitis B Vaccine	Where: _____	*MM/DD/YYYY* ____/___/____	Tetanus Diphtheria Pertussis (Tdap)	Where: _____	*MM/DD/YYYY* ____/___/____
Flu Vaccine	Where: _____	*MM/DD/YYYY* ____/___/____	Pneumovax 23 (pneumonia #2)	Where: _____	*MM/DD/YYYY* ____/___/____
Zostavax (shingles)	Where: _____	*MM/DD/YYYY* ____/___/____	Prevnar 13 (pneumonia #1)	Where: _____	*MM/DD/YYYY* ____/___/____

Health Screenings: If you do not know the exact date, **please gather and bring this information with you to the appointment.**

Hearing Exam:	Where: _____	*MM/DD/YYYY* ____/___/____	Abdominal Aortic Aneurysm Screening	Where: _____	*MM/DD/YYYY* ____/___/____
Dental Exam	Where: _____	*MM/DD/YYYY* ____/___/____	Eye/Glaucoma Exam	Where: _____	*MM/DD/YYYY* ____/___/____
Colonoscopy	Where: _____	*MM/DD/YYYY* ____/___/____	Stool test for blood (fecal occult blood)	Where: _____	*MM/DD/YYYY* ____/___/____
Cholesterol Panel	Where: _____	*MM/DD/YYYY* ____/___/____	Electrocardiogram (EKG)	Where: _____	*MM/DD/YYYY* ____/___/____
ECHO	Where: _____	*MM/DD/YYYY* ____/___/____	Bone Density Scan (DEXA)	Where: _____	*MM/DD/YYYY* ____/___/____

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Health Screenings (continued) If you do not know the exact date, **please gather and bring this information with you to the appointment.**

Men:			**Women:**		*MM/DD/YYYY* ___/___/___
Prostate Exam	Where: _____	*MM/DD/YYYY* ___/___/___	Mammogram	Where: _____	*MM/DD/YYYY* ___/___/___
PSA (blood test)	Where: _____	*MM/DD/YYYY* ___/___/___	Pap Smear	Where: _____	*MM/DD/YYYY* ___/___/___

Social History:

Alcohol Use: ☐ Current ☐ Past ☐ Never	Average drinks per episode in the past year: ____
Type: ☐ Beer ☐ Wine ☐ Liquor ☐ Other:_____	Maximum drinks per episode in the past year:___
Started at age: _____	Stopped at age: _____

Previous treatment: ☐ None ☐ Alcoholics Anonymous ☐ Inpatient ☐ Outpatient ☐ Other: _____

How often do you have a drink of alcohol? (*A drink of alcohol is considered any of the following: 12oz beer, 5oz glass of wine, 1.5oz liquor [one shot]*)	☐ Never ☐ 1-2x per year ☐ 1-2x per month ☐ 1-2x per week	☐ 3-5x per week ☐ Daily ☐ Several times per day

Has alcohol use **interfered with work or home** life? ☐ Yes ☐ No	Do you ever **drink more than intended?** ☐ Yes ☐ No
Has anyone been **hurt or at risk** by your drinking? ☐ Yes ☐ No Ready to change? ☐ Yes ☐ No	Do you have any concerns **about alcohol use** in your household? ☐ Yes ☐ No

Tobacco/Substance Use

Have you ever **smoked** tobacco? ☐ Never (less than 100 in life time) ☐ Former ☐ Current	Have you ever **chewed** tobacco? ☐Never ☐ Former ☐ Current
If you currently smoke or chew, **would you like to quit?** ☐ Yes ☐ No	Do you have a **history of IV drug use?** ☐ Yes ☐ No

Employment/School

☐ Employed full time ☐ Part time ☐ Retired ☐ Unemployed	Summarize your current or previous employment:_____

Home Environment

Describe your **current living situation:**	☐ Home/Independent ☐ Home with assistance	☐ Homeless/shelter ☐ Other:_____
Who do you live with?	☐ Self ☐ Children ☐ Mother ☐ Father	☐ Roommate(s) ☐ Significant other ☐ Spouse ☐ Other:_____

Nutrition/Health

Type of diet (if any):	☐ Regular ☐ Calorie Restricted ☐ Other:_____	☐ Vegetarian ☐Diabetic
Do you have any **sleeping concerns?**	☐ Yes ☐ No	
Do you **feel highly stressed**?	☐ Yes ☐ No	

Exercise

Average **duration of exercise** (in minutes):_____		
How frequently do you exercise in an average week?	☐ 1-2 times per week ☐ 3-4 times per week ☐ 5-6 times per week ☐ Daily	
Exercise Type:	☐ Aerobics ☐ Daily Bicycling ☐ Organized sports ☐ Running ☐ Other:_____	☐ Swimming ☐ Walking ☐ Weight Lifting ☐ Yoga

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Mental Health Questionnaire (PHQ-9) Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle to indicate your answer.)		Not At All	Several Days	More than half the days	Nearly Every Day
1)	Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2)	Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3)	Trouble falling asleep, staying asleep or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4)	Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5)	Poor appetite or over eating	☐ 0	☐ 1	☐ 2	☐ 3
6)	Feeling bad about yourself – or that you're a failure or have let yourself or family down	☐ 0	☐ 1	☐ 2	☐ 3
7)	Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8)	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9)	Thoughts that you would be better off dead or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

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Home Safety Screening	
Are emergency numbers kept by the phone and regularly updated?	☐Yes ☐No
Are all household members aware of the dangers of smoking, especially in bed?	☐Yes ☐No
Are working smoke alarm(s) and fire extinguisher(s) available for use?	☐Yes ☐No
Do all household members know how to use them?	☐Yes ☐No
Are firearms stored unloaded and securely locked?	☐Yes ☐No
Have throw rugs been removed or fastened down?	☐Yes ☐No
Are non-slip mats in all bathtubs and showers?	☐Yes ☐No
Do all stairways have a railing or banister?	☐Yes ☐No
Are sidewalks and all outdoor steps clear of tools, toys, or other articles?	☐Yes ☐No
Are doors, halls, and stairs free of clutter?	☐Yes ☐No
Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?	☐Yes ☐No
Fall Risk Assessment	
History of falling in the last 3 months (including since admission?)	☐Yes ☐No
Do you ever experience dizziness or vertigo?	☐Yes ☐No
Do you ever wet or soil yourself on the way to the bathroom?	☐Yes ☐No

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Advanced Directive	
Do you have an advanced directive?	☐Yes ☐No
If **NO**, would you like more information on them?	☐Yes ☐No
If **YES**, fill out questions below. ⬇	
What was the date was finalized?	____/____/_____
What is the name of your surrogate?	
What **type** of advanced directive do you have?	
☐ Organ/tissue donation ☐ Living will ☐ Medical durable power of attorney ☐ MOLST (Medical orders for life-sustaining treatment) ☐ POLST (physician orders for life sustaining treatment.)	☐ Healthcare proxy ☐ Legal guardian ☐ Activated healthcare power of attorney ☐ Other _____ _____
Are you a documented organ/tissue donor? (On driver's license or within advanced directive?)	☐Yes ☐No
Where is your advanced directive located? (if the clinic does not have a copy, please **bring with you to your appointment.**)	_____ _____ _____

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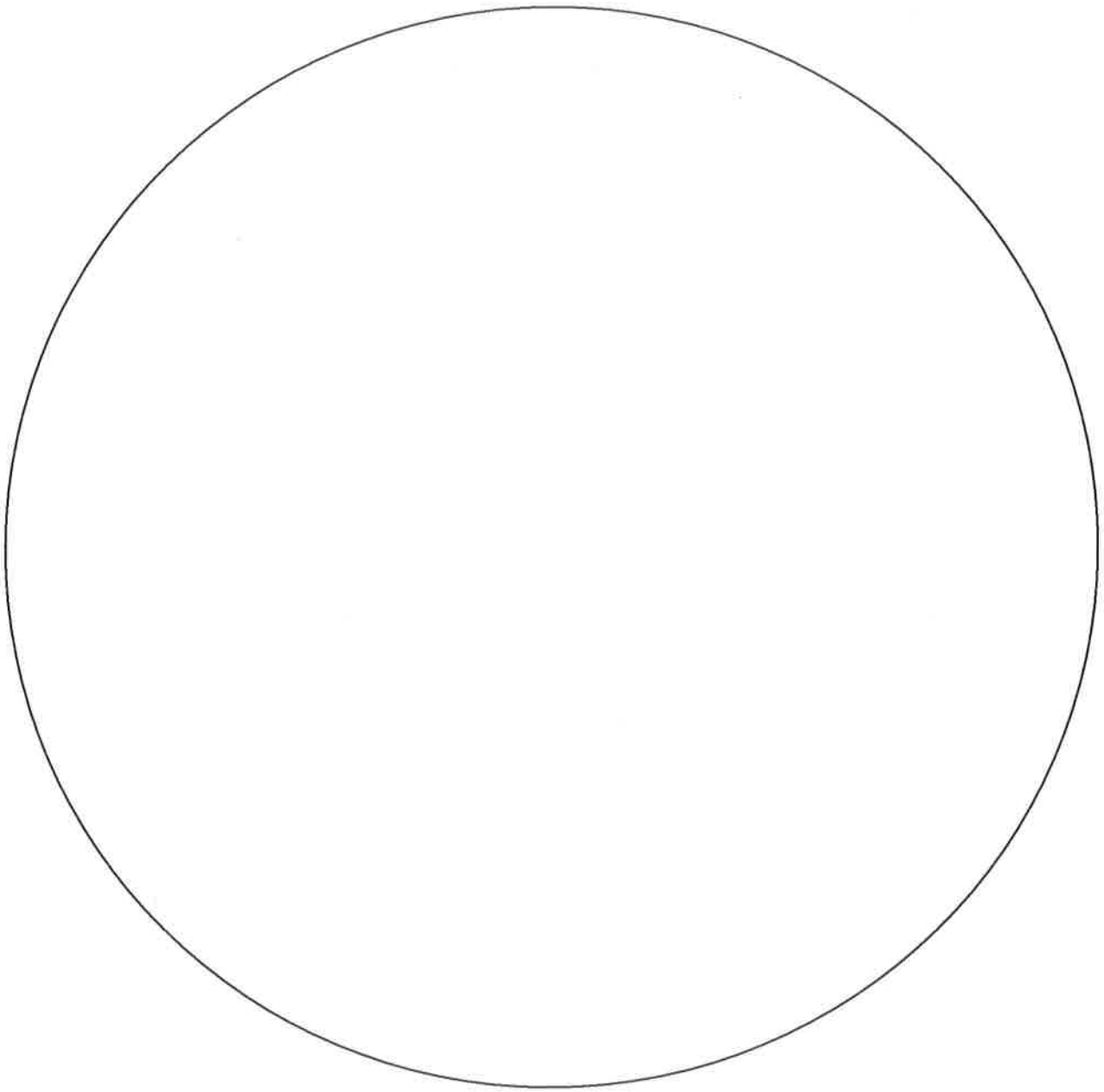
For clinic staff use. Do not mark this page until instructed.



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