Bradley M. Burton, M.D.
E. Evan Holmstead, M.D.
Mallory Driscoll, PA-C

MOUNTAIN VIEW
family medicine

2006 Birdie Thompson Drive
Pocatello, Idaho 83201
208-232-1132
208-232-1134 (fax)

PATIENT NAME:_____ DATE:_____

MEDICAL HISTORY: (please list any illnesses, injuries or other problems you have seen a doctor about)

_____

_____

SURGERIES: (please list any past surgeries you have had done - when and where)

_____

_____

HOSPITALIZATIONS: (please list any overnight hospital stays - excluding normal pregnancies)

_____

_____

OB/GYN HISTORY: (females)

Age of 1st Menstrual Cycle:_____ Age of Menopause:_____ Number of Pregnancies:_____
Full-term Births:_____ Pre-term Births:_____ Miscarriages:_____ Living Children:_____
Type of Delivery:_____ Pregnancy Complications:_____

FAMILY HISTORY:

	AGE IF LIVING	HEALTH PROBLEMS	AGE & CAUSE OF DEATH
FATHER:			
MOTHER:			
SISTER(S):			
BROTHER(S):			
CHILDREN:			

PREVENTION: (when was your last)

Tetanus Shot:_____
Pneumonia Shot:_____
Pap Smear:_____
Mammogram:_____
Cholesterol Check:_____

Allergies to Past Medications:

_____

_____

What Happened:

_____

HABITS AND ACTIVITIES:

Do You Drink Alcohol:_____ If yes, how much and how often:_____
Do You Smoke or Use Tobacco:_____ If yes, how much and how long:_____
Are Currently Exercising:_____ If yes, type and frequency:_____
Hobbies and Leisure Activities:_____

MEDICAL ILLNESSES: (please mark all that apply)

YOU	FAMILY	ILLNESS	YOU	FAMILY	ILLNESS
____	____	DIABETES	____	____	THYROID DISEASE
____	____	HIGH BLOOD PRESSURE	____	____	GALLBLADDER
____	____	HEART DISEASE	____	____	LIVER DISEASE
____	____	STROKE	____	____	ULCER
____	____	BLOOD CLOTS	____	____	ANEMIA OR BLEEDING
____	____	CANCER	____	____	MIGRAINE HEADACHES
____	____	ASTHMA OR ALLERGIES	____	____	ARTHRITIS
____	____	PNEUMONIA OR TB	____	____	OSTEOPROROSIS
____	____	KIDNEY PROBLEMS	____	____	BONE FRACTURE
____	____	DEPRESSION OR ANXIETY	____	____	SEXUALLY TRANSMITTED DISEASE