GREENVILLE HEALTH SYSTEM

Mountain View Family Practice
406 Memorial Drive Ext Greer, SC 29651
(864) 877-9066

Today's Date __/__/__

PHYSICIAN: ☐ Dr. Ballard ☐ Dr. Byars ☐ Dr.Labotka ☐ Dr. Lawrence ☐ Dr. Leigh ☐ PA Johnson

PATIENT NAME **DOB**

PRIMARY CARE PHYSICIAN

WERE YOU REFERRED?
☐ No ☐ Yes – By Whom ____________________

CHIEF COMPLAINT: Where is the problem? Area of Body: __________ Which side? ☐ Right ☐ Left

MEDICAL HISTORY: Have you **ever** had or do you **now** have any of the following? ☐ **None / Healthy**

☐ Angina	☐ AIDS / HIV	☐ Gout	☐ Osteoporosis
☐ Arthritis	☐ COPD/ Emphysema	☐ Hepatitis	☐ Kidney Disease
☐ Asthma	☐ Heart Disease	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ Depression	☐ High Blood Pressure	☐ Sleep Apnea
☐ Cancer	☐ Diabetes	☐ Myocardial infarction/MI	☐ Systemic Lupus
☐ Stroke	☐ DVT/ Blood clot	☐ Neuropathy	☐ Thyroid Disease
☐ Concussion	☐ Fibromyalgia	☐ Liver Disease	☐ Spinal Stenosis
☐ Congestive Heart Failure	☐ GERD/ Acid Reflux	☐ Peptic Ulcer Disease	☐ Other (write below)

Other ____

SURGICAL HISTORY: **(Please check the types of surgery you have had and write the approximate year the surgery was performed.)** ☐ **None** **R- Right** **L- Left** **B- Both**

SURGERY	YEAR	SURGERY	YEAR
☐ ACL surgery - R / L		☐ Knee Replacement R / L	
☐ Angioplasty / Heart		☐ Laminectomy	
☐ Appendix		☐ Discectomy	
☐ Arthroscopy knee R / L		☐ Pacemaker	
☐ Arthroscopy shoulder R /L		☐ Rotator Cuff Repair R / L	
☐ Back (disc or fusion)		☐ Thyroids	
☐ Bone / Fracture Repair		☐ Tonsils / Adenoids	
☐ CABG / bypass surgery		☐ Blood Vessels	
☐ Carpal Tunnel R / L		☐ Other : C-Section	
☐ Cataract surgery		☐ Other: Hysterectomy	
☐ Gallbladder		☐ Other: Breast /mastectomy R/L	
☐ Colon / Bowel / Intestinal		☐ Other: Ovary / Tube	
☐ Gastric Bypass		☐ Other: Prostate / Bladder	
☐ Hernia		☐ Other: Kidney	
☐ Hip Replacement R / L		☐ Other: Lung	
Other Surgery:			
Other Surgery:			

ALLERGIES TO MEDICATIONS ☐ None Known

☐ Aspirin ☐ Penicillin ☐ Other:______________________

☐ Codeine ☐ Sulfa ☐ Latex

FAMILY HISTORY (What runs in your family?) ☐ **None**

☐ Cancer ☐ Gout ☐ Kidney Disease ☐ Arthritis

☐ Diabetes ☐ Heart Disease ☐ Liver Disease ☐ Osteoporosis

SOCIAL HISTORY ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

SMOKING: ☐ No ☐ Yes If yes, packs per day? ______ Years smoking? ______ ☐ Quit, year ________

ALCOHOL: ☐ None ☐ Socially ☐ Rarely ☐ Occasionally ☐ Yearly ☐ Weekly ☐ Daily

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

CHILDREN: ☐ No ☐ Yes Number of sons: _______ Number of daughters: ________

OCCUPATION: ____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS ACCURATE.

________________________________ **Date:** ____________________

Patient's/ Legal Guardian Signature