MOUNTAIN INTEGRATIVE MEDICINE, PLLC
Danna Park, MD, FAAP, FACP

138 Charlotte Street, Suite 203 Asheville, NC 28801
ph: 828.333.3339 fax: 828.254.3114
email: mountainintegrative@outlook.com

PATIENT INFORMATION

Name_____ Age_____ Date of Birth_____

Address_____ Email_____

Home Phone_____ Cell Phone_____

Preferred contact phone number _____	Yes	No
Provider can leave detailed message on cell phone voicemail	___	___
Provider can leave only name and phone number on cell phone VM	___	___
Provider can leave detailed message on home phone voice mail	___	___
Provider can leave only name and phone number on home phone VM	___	___
Provider can email messages such as appointment times/reminders	___	___
Provider may contact me at work	___	___

(initial here)_____I understand that email messages with appointment times and reminders may not be encrypted or sent from a secure server but that any information about my condition, or follow up questions will be sent via secure encrypted email from Mountain Integrative Medicine, PLLC. I understand that if I choose to not reply using the secure/encrypted email link, that Mountain Integrative Medicine, PLLC is not responsible for breaches in protected health information, and that this responsibility to maintain integrity of secure encrypted information belongs to Privacy Data Systems, Inc.

Emergency Contact _____Relationship to Contact_____

With whom may we discuss your account?_____

With whom may we discuss your medical condition?_____

Primary care provider name and address_____

Specialist(s) names and addresses_____

_____

(initial here)_____I authorize Mountain Integrative Medicine, PLLC to contact my primary care and/or specialist providers and provide them with a copy of my Integrative Medicine consultation.

Who lives at home with you?_____

Reason for seeking integrative medicine consultation?_____

_____

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Out of all your concerns/questions that you have, what is the top concern or question you would like to make sure we discuss/address today?_____

_____

_____

Past Medical History- Please list any illnesses, hospitalizations or surgeries you have had and dates:

_____

_____

_____

_____

Allergies:_____

Current Medications (name, amount, how many times a day):

_____

_____

_____

_____

_____

Current supplements/vitamins/herbs/protein powders (give brand name when possible, amount/day):

_____

_____

_____

_____

_____

Family History- Please list any illness for mother/father/siblings/grandparents (heart disease, hypertension, cancer, etc):_____

_____

_____

_____

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Do you drink alcohol? _____ If yes, how much_____

Do you smoke or chew tobacco?_____ If yes, how many cigarettes/day?_____ If no, when did you quit?_____

Any recreational drug use?_____

Review of Systems- Please check the following symptoms that bother you frequently:

____high blood pressure
____glaucoma
____macular degeneration
____hearing loss or ringing in the ears
____weight loss or weight gain
____fever/chills
____seizures
____headaches
____migraine headache
____seasonal allergies
____dizziness
____difficulty swallowing
____diabetes
____thyroid problems
____irregular heart beats
____chest pain
____heart murmur
____lung disease
____asthma
____chronic cough
____nausea
____abdominal pain or bloating
____diarrhea
____liver disease
____swelling in legs or ankles
____enlarged glands
____breast lumps/fibrocystic disease
____menopausal symptoms
____joint pain
____skin rashes
____difficulty urinating
____incontinence
____blood transfusion? When?_____

Are you currently using or have you used complementary/alternative/integrative medicine or modalities? If yes, what? _____

_____

_____

Anything else you think is important for us to know?_____

_____

_____