



## History & Physical Form

### Mi Via, NM Self-Directed Medicaid Waiver Program

(If your office or practice has its own H&P it may be used. Please see delivery instructions bottom Page 2.)

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### Vital Signs

Pulse:                      Resp:                      Temp:                      BP:

Ht:                      Wt:

Diagnosis(es):

Current Medications (including OTC and supplements, if known):

Brief medical history, with specific attention to reasons for any disability (may be physical and/or cognitive/behavioral):

General/Constitutional:

Skin/Breast:

Eyes/Ears/Nose/Mouth/Throat:

**Continued, Mi Via, History & Physical Participant Name:** \_\_\_\_\_

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Neurologic/Psychiatric:

Allergic/Immunologic/Lymphatic/Endocrine:

Follow up/Comments:

**Provider (MD, DO, CNP or PAC only) Signature and Title:**

\_\_\_\_\_

Office Telephone: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mail or Fax to:**  
**Molina- Third Party Assessor**  
**P.O. Box 3909**  
**Albuquerque, NM 87190**  
**Fax: (866) 553-9268, (866) 553-9272 or**  
**(866) 553-9359**

**Please Hand Deliver to:**  
**Molina-Third Party Assessor**  
**8801 Horizon Blvd. NE**  
**Albuquerque, NM 87113-1533**