MONTAGE Medical Group

Date: _____

Patient: _____ Date of Birth: _____

Allergies (Drug/Medication/Food/Environmental)	**Reaction**	**Severity**
Example: *Penicillin*	*Nausea*	*Moderate*

Medications	**Dose**	**Frequency**	**Prescriber**
Example: *Metoprolol*	*25 mg*	*1 tablet two times daily*	*Dr. John Smith*
Attach additional sheet if necessary.			

Other Providers/Specialists	**Specialty**
Example: *Dr. John Smith*	*Chiropractor*
Attach additional sheet if necessary.	

Preferred Local Pharmacy:
Preferred Mail Order Pharmacy, if applicable:

Laboratory – In the last 12 months, where have you received laboratory services? Please list Lab name(s).

MONTAGE Medical Group

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Advanced Care Planning – Please provide a copy.			
□ Living Will	□ POLST	□ Advanced Directive	□ I would like more information about Advanced Care Planning

History of Vaccines and Screenings	**Yes**	**No**	**Date**	**Provider or Location**
Have you received a flu shot this season?				
Have you ever received a vaccine for pneumonia?				
If you are over the age of 50:	**Yes**	**No**	**Date**	**Provider or Location**
Have you had a Fecal test (stool card) in the last year?				
Have you had a colonoscopy in the last 10 years?				
If you are Female:	**Yes**	**No**	**Date**	**Provider or Location**
Have you had a mammogram in the last 5 years?				
If you are Diabetic:	**Yes**	**No**	**Date**	**Provider or Location**
Have you had a diabetic foot exam in the last year?				
Have you had a diabetic eye exam in the last year?				

Endocrine Past Medical History – Check all that apply.		
Diagnosis of Osteoporosis or Osteopenia	□ Yes - Year Diagnosed _____	□ No
History of a Fracture	□ Yes - Year Diagnosed _____	□ No
History of frequent falls or balance issues	□ Yes	□ No
History of steroid use longer than 3 months	□ Yes	□ No
Diagnosis of Hypothyroidism	□ Yes - Year Diagnosed _____	□ No
Diagnosis of Hyperthyroidism	□ Yes - Year Diagnosed _____	□ No
History of Thyroid Nodule	□ Yes - Year Diagnosed _____	□ No
History of Thyroid Cancer	□ Yes - Year Diagnosed _____	□ No
Have you ever had a radioactive iodine update scan?	□ Yes	□ No
Have you ever had radioactive iodine ablation/treatment for Thyroid Cancer?	□ Yes	□ No
Females: Are you planning to become pregnant?	□ Yes	□ No

MONTAGE Medical Group

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Diabetes Past Medical History – Check all that apply.			
Diagnosis of Diabetes	□ Yes - Year Diagnosed: _____		□ No
Currently using an Insulin Pump	□ Yes - Settings: _____		□ No
How often do you **miss** your medication?	□ Never (0 times)	□ Sometimes (less than 2 times per week)	□ Always (I never take it)
How many times per day to you check your blood sugars?	□ 1	□ 2	□ 3 or more

Past Medical History Continued – Check all that apply.			□ **NONE**
□ Allergies	□ Benign Prostatic Enlargement	□ GERD	□ Migraine Headaches
□ Anemia	□ Blood Clots	□ Heart Attack	□ Osteoporosis
□ Angina	□ Cancer: _____	□ Hepatitis C	□ Mental Health Illness: _____
□ Anxiety	□ COPD	□ High Cholesterol	□ Peptic Ulcer Disease
□ Arthritis	□ Coronary Artery Disease	□ High Blood Pressure	□ Seizure Disorder
□ Asthma	□ Crohn's Disease/Colitis	□ Irritable Bowel Disease	□ Other: _____
□ Atrial Fibrillation	□ Depression	□ Kidney Disease	□ Other: _____
□ Back Pain	□ Gallbladder Disease	□ Liver Disease	□ Other: _____

Past Surgical History – Check/circle all that apply. □ **NONE**

Surgery	Year	Surgery	Year	Surgery	Year
□ Angioplasty		□ Cholecystectomy (Gallbladder Removal)		□ Mastectomy	
□ Appendectomy (Appendix Removal)		□ Colectomy		□ Open Reduction Internal Fixation (ORIF): _____	
□ Arthroscopy Area: _____		□ Colostomy		□ Prostate Surgery	
□ Back Surgery		□ Dilation & Curettage (D&C)		□ Thyroidectomy	
□ Blood Transfusion		□ Gastric Bypass		□ Tonsillectomy	
□ Coronary Artery Bypass Grafting (CABG)		□ Hip Replacement LEFT RIGHT		□ Uterine Surgery	
□ Cardiac Pacemaker		□ Hysterectomy		□ Vasectomy	
□ Carpal Tunnel Release LEFT RIGHT		□ Knee Replacement LEFT RIGHT		□ Other: _____	
□ Cataract Extraction LEFT RIGHT		□ LASIK LEFT RIGHT		□ Other: _____	

MONTAGE Medical Group

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Family History – Check all that apply.						
	Mother □ None	**Father** □ None	**Sister** □ None	**Brother** □ None	**Daughter** □ None	**Son** □ None
Alzheimer's Disease						
Arthritis						
Asthma						
Cancer: _____						
Cardiovascular Disease						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Mental Health Illness: _____						
Osteoporosis						
Seizure Disorder						
Stroke						
Substance Use: _____						
Thyroid Disorder						

Tobacco Use

Have you ever used Tobacco? □ No □ Yes

□ Former Smoker | □ Current Smoker, Every Day | □ Current Smoker, Some Days

Alcohol Use

□ No | □ Yes | □ Formerly Drank Alcohol Year Quit _____

If Yes:

Alcohol Type: □ Beer □ Wine □ Liquor □ Other: _____

Frequency: □ Daily □ Weekly □ Monthly □ Occasionally

Quantity: □ 1 Drink □ 2 Drinks □ 3 Drinks □ More than 3 drinks

Caffeine Intake

□ No | □ Yes - Caffeine Type □ Coffee □ Soda □ Energy Drinks □ Other: _____ Total cup(s) per day _____

Occupation – Please list your occupation.

Employment Status

□ Full Time | □ Part Time | □ Active Military

□ Retired | □ Disabled | □ Unemployed

□ Other:

MONTAGE Medical Group

Patient: _____ Date of Birth: _____

Marital Status				
□ Single	□ Married	□ Domestic Partner	□ Divorced	□ Widow/Widower

Children			
□ No	□ Yes	Number of Sons _____	Number of Daughters _____

Housing Status		
□ Permanent	□ Temporary	□ Unstable/Homeless
Residence – Patient lives with:		
□ Spouse or Domestic Partner	□ Son	□ Daughter
□ Alone	□ Assisted Living Facility:	□ Other:

Exercise	
Type: _____ _____ _____	Frequency □ Occasional □ 2-3 times a week □ 4-5 Times a week □ Daily

Communication Needs	**Yes**	**No**
Do you have difficulty with hearing?		
Do you have difficulty with your vision?		
Have you had difficulty remembering things that have happened recently?		

My Personal and Lifestyle Goals – Check all that apply.	
□ Eat a healthier diet	□ Get regular physical activity
□ Achieve/maintain a healthy weight	□ Maintain a cheerful, hopeful outlook on life
□ Get adequate rest daily	□ Other:

I believe I am not meeting my lifestyle goals because:

_____

_____

Substance Use		
□ No	□ Yes	□ Former substance user

I certify that the information provided is correct to the best of my knowledge.

_____ _____
Signature Date

_____ _____
Print Guardian Name (if other than patient) Relationship