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).

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

MONTAGE Medical Group

Patient: _____ Date of Birth: _____

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?				

Past Medical History – Check all that apply. □ **NONE**

□ Allergies	□ Benign Prostatic Enlargement	□ Gallbladder Disease	□ Liver Disease
□ Anemia	□ Blood Clots	□ GERD	□ Migraine Headaches
□ Atrial Fibrillation	□ Cancer: _____	□ Heart Attack	□ Mental Health Illness _____
□ Anxiety	□ COPD	□ Hepatitis C	□ Osteoporosis
□ Arthritis	□ Coronary Artery Disease	□ High Cholesterol	□ Peptic Ulcer Disease
□ Asthma	□ Crohn's Disease/Colitis	□ High Blood Pressure	□ Seizure Disorder
□ Angina	□ Depression	□ Irritable Bowel Disease	□ Thyroid Disease
□ Back Pain	□ Diabetes	□ Kidney Disease	□ Other: _____

Sexually Transmitted Disease: _____ Treatment: _____ Symptoms: _____

Obstetric History		
Total number of Pregnancies:____	Total number carried to term:___	Total number Pre-Term:____
Total number of Miscarriages:____	Total number of Terminations:____	Total number Ectopic:____
What was the age of your first period? :_____		

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Patient: _____ Date of Birth: _____

History of Sexually Transmitted Diseases	□ **NONE**
Type:_____	Treatment:_____
Current Symptoms:_____	

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

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

Family History – Check all that apply.

	Mother □ None	**Father** □ None	**Sister** □ None	**Brother** □ None	**Daughter** □ None	**Son** □ None
Alzheimer's Disease						
Arthritis						
Asthma						
Cardiovascular Disease						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Mental Health Illness: _____						
Osteoporosis						
Seizure Disorder						
Stroke						
Substance Use:_____						
Thyroid Disorder						
Other:_____						

MONTAGE Medical Group

Patient: _____ Date of Birth: _____

Family History of Cancer – Check all that apply.							
	Mother □ None	**Father** □ None	**Sister** □ None	**Brother** □ None	**Daughter** □ None	**Son** □ None	**Other Family:** _____
Breast Cancer							
Ovarian Cancer							
Colon Cancer							
Endometrial Cancer							
Pancreatic Cancer							
Prostate Cancer							
Other: _____							

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 _____

Previous Occupation – Please list your previous occupation, if applicable.

Current Occupation – Please list your current occupation.

Current Employment Status

□ Full Time □ Part Time □ Active Military

□ Retired □ Disabled □ Unemployed

□ Other:

Education– Please list your highest level of education.

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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