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).

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Patient: ______________________________ Date of Birth: ____________________

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?				

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

Patient: ______________________________ Date of Birth: ____________________

Psychiatric History – Check all that apply.							☐ **NONE**
☐	ADHD	☐	Anxiety	☐	Depression	☐	Bipolar Disorder
☐	Personality Disorder	☐	Panic Disorder	☐	Obsessive Compulsive Disorder	☐	Paranoid Schizophrenia
☐	Post-Traumatic Stress Disorder			☐	Other: ______________	☐	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: ____________________	

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						
Other:____________________						

MONTAGE Medical Group™

Patient: ______________________________ Date of Birth: ______________

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:		

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

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

Housing Status		
☐ Permanent	☐ Temporary	☐ Unstable/Homeless

Patient: ______________________ Date of Birth: ______________

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