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).

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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?				

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
□ Anxiety	□ COPD	□ Hepatitis C	□ Peptic Ulcer Disease
□ Arthritis	□ Coronary Artery Disease	□ High Cholesterol	□ Seizure Disorder
□ Asthma	□ Crohn's Disease/Colitis	□ High Blood Pressure	□ Thyroid Disease
□ Atrial Fibrillation	□ Depression	□ Irritable Bowel Disease	□ Mental Health Illness: _____
□ Back Pain	□ Diabetes	□ Kidney Disease	□ Other: _____

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Patient: _____ Date of Birth: _____

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						
Bleeding Disorder						
Blood Clots						
Cancer: _____						
Cardiovascular Disease						
Depression						
Diabetes						
Emphysema						
High Cholesterol						
High Blood Pressure						
Mental Health Illness: _____						
Osteoporosis						
Seizure Disorder						
Stroke						
Substance Use: _____						
Thyroid Disorder						
Other: _____						

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Patient: _____ Date of Birth: _____

Recent Diagnostic Studies		□ **No Recent Diagnostic Studies**
Study	**Date (or approximate date)**	**Location**
Pulmonary Function Test (PFT)		
Chest X-Ray		
CT Scan (Cat Scan) of the chest.		
Bronchoscopy		
Lung Biopsy		
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:		

MONTAGE Medical Group

Patient: _____ Date of Birth: _____

Education– Please list your highest level of education.

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: _____ _____	

Exposure -- Check all that apply.
Have you ever been exposed to any of the following: Mold? □ Yes □ No Asbestos? □ Yes □ No Farm Animals? □ Yes □ No
Do you have any pets or birds? □ No □ Yes Types:_____
Have you traveled out of the state in the last 6 months? □ No □ Yes Area:_____

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Substance Use		
□ No	□ Yes	□ Former substance user

Epworth Sleepiness Score

Directions: On a scale of 0 to 3, how likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. If you have not done some of these things recently, try to imagine how they would affect you.

0 = I would **never** doze off.

1 = There is a **slight** chance I would doze off.

2 = There is a **moderate** chance I would doze off.

3 = There is a **high** chance I would doze off.

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place, such as a theatre or a meeting				
As a passenger in a car for an hour without break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car when stopped for a few minutes in traffic				

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

_____ _____

Signature Date

_____ _____

Print Guardian Name (if other than patient) Relationship