BLUE MOUNTAIN FAMILY MEDICINE
610 N. California St. Missoula, MT 59802
MEDICAL HISTORY
ALL INFORMATION IS CONFIDENTIAL

Date_____

Have you ever been a patient at Blue Mountain Clinic before?___Yes (date_____) ___No
Reason For Visit_____
Legal Name(*please include middle initial and maiden name*)_____
Preferred Name_____What pronoun do you use?_____Birthdate___/___/___SS #_____/____/_____
Address_____City_____State___ZIP_____
Primary Phone_____E-mail_____
Employer_____Work Phone_____
Parent or guardian's name_____Phone Number_____
Emergency Contact: Name_____Phone_____Relationship_____
Special Instructions for contacting you, including the use of your preferred name:

_____

Are you establishing Primary Care or care for Contraception/Abortion/IUD/Nexplanon/STI testing only?
Primary care ☐ Contraception/Abortion/IUD/Nexplanon/STI testing ☐ Both ☐
FAMILY MEDICAL HISTORY: (Include parents and siblings)
Heart Disease _____ Stroke_____
Diabetes_____ Aortic Aneurysm_____
High Blood Pressure_____ Other_____
Cancer: ☐Colon_____ ☐Breast_____ ☐Other Cancer _____
PERSONAL MEDICAL HISTORY: (Include past and present)
Age____Height____Weight____Blood type____Date of last Physical Exam_____
Allergies to Medication_____

_____
Shellfish allergy ____yes ____no Latex allergy ____ yes ____no
Current Medications & Doses (attach list if needed) **Pharmacy of Choice:**_____

Name	Strength in mg/ml	Number of times a day taken

Specialist clinics or physicians you currently see:_____

_____

Surgeries, Hospitalizations: **(list year if can)**

_____

_____

For Everyone Please answer and comment if needed. **Do you have any of the following?**

Do You Smoke? Yes No If yes, how much_____ If you quit, when?_____

☐ Eye/Ear Disease	☐ Asthma	☐ COPD	☐ Blood clot disease / DVT/PE	☐ Anemia /Blood disorder	☐ Gender Fluidity
☐ High cholesterol	☐ Atrial fibrillation	☐ Heart attack/ heart disease	☐ Murmur/Heart Valve disease	☐ Hypertension	☐ Diabetes
☐ Chronic Constipation/Diarrhea	☐ Irritable Inflammatory Bowel disease	☐ Anxiety	☐ Depression	☐ Bipolar	☐ Other mental health disease

☐ ADD/ADHD	☐ Brain Injury	☐ Kidney Disease	☐ Recurrent UTI/ bladder disease	☐ Kidney stones	☐ GERD/reflux disease/ulcer
☐ Endometriosis	☐ Ovarian Cysts	☐ Uterine Fibroids	☐ Thyroid disease	☐ Herpes	☐ Hepatitis/HIV
☐ Arthritis	☐ Fibromyalgia	☐ Migraines /Headaches	☐ Gout	☐ Osteoporosis	☐ Rheumatological Disease/MS
☐ Breast Cancer	☐ Colon Cancer/polyps	☐ Prostate Cancer	☐ Other cancer	☐ Obesity	☐ Addiction issues

Comments on above_____

_____

Sexual HISTORY:

Are you currently sexually active? ___Yes ___No

Are you concerned about any current possibilities of sexually transmitted infections? ___Yes ___NO

Have you undergone any gender confirming surgery? ___ Yes ___ No

If yes please list _____

Gynecological history IF APPLICABLE: ☐ N/A

Do you have a current method of Birth Control? _____Yes ___No type:_____

How long have you used?_____ Problems?_____

Do you see yourself desiring a pregnancy in the next year? _____Yes _____No

Are you postmenopausal? ___ Yes ____ No Have you had a hysterectomy? ___ Yes ____ No

What was the first day of your last menstrual period?_____Date of last Pap Smear_____.

Have you ever had any of the following?

1. Abnormal Pap Smear ___Yes ___No Dates & Treatment_____
2. Migraines with aura ___Yes ___No
3. Blood clot disorder or blood clot in your leg or lungs? ____Yes ___No

Do you have regular periods? ___Yes ___No ____ Post Menopause Problems_____

Do you think you might be pregnant now? ___Yes ___No

Have you had intercourse without birth control since your last period? ___Yes ___No

Previous pregnancies? ___Yes ___No Date last pregnancy ended? _____

Live births #____ Abortions#____ Miscarriages#____ Still births# _____

Ectopic# ____ Cesarean# ____ Multiple births____Deceased children ____

Prevention (50 Years or older)

	Year	Result		Year	Result
Bone dexa scan			Hepatitis C screen		
Colon Cancer test Colonoscopy ☐			Shingles vaccine		
Abdominal Aortic Aneurysm Screen			Pneumonia vaccine		

Have you had falls in the last month? (over 50 yo) ____Yes ____No How many?_____

Do you have a health care power of attorney or code status designated? ____Yes ____No

Would you like advice on this today? ____Yes ____No

Do you have urinary incontinence? ____Yes ____No

Blue Mountain Clinic may verbally exchange health information with person or organization named below

_____

**All information on this medical history is strictly confidential. We will not release this information to anyone without your