

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? _____

<input type="checkbox"/> Eye/Ear Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Blood clot disease / DVT/PE	<input type="checkbox"/> Anemia /Blood disorder	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Heart attack/ heart disease	<input type="checkbox"/> Murmur/Heart Valve disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chronic Constipation/Diarrhea	<input type="checkbox"/> Irritable Inflammatory Bowel disease	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Other mental health disease

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Recurrent UTI/ bladder disease	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> GERD/reflux disease/ulcer
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Herpes	<input type="checkbox"/> Hepatitis/HIV
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Migraines /Headaches	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatological Disease/MS
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer/polyps	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Other cancer	<input type="checkbox"/> Obesity	<input type="checkbox"/> 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			Shingles vaccine		
Colonoscopy <input type="checkbox"/>					
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