BLUE MOUNTAIN CLINIC

610 N. California St. Missoula, MT 59802

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

Patient #_____

Date_____

Have you ever been a patient at Blue Mountain Clinic before?____Yes (date_____) ___No

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:_____

_____

_____

Reason for today's visit_____

_____

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)

Allergies to Medication_____

_____

Other allergies_____

_____

Current Medications & Doses (prescription and other)_____

_____ _____

_____

Age____Height____Weight____Blood type____Date of last Physical Exam_____

	Yes	Comments/Dates
Habits: Alcohol	____	_____
Tobacco	____	_____
Respiratory: Lung/Sinus problems, Asthma	____	_____
Cardiac: High Blood Pressure, Heart Murmur, High Cholesterol, Blood Clotting disorder	____	_____

Gastrointestinal Problems: Liver, Stomach, Gallbladder, Bowel, Heartburn ____ _____

Joint Problems: Pain, Swelling, Injury ____
Arthritis _____

Genital/Urinary Problems: Bladder, STD's ____ _____

Kidney, Sexual Function, Other _____

Hormonal: PMS, Diabetes, Thyroid, Other ____ _____

Neurologic: Migraines, Seizures, Other ____ _____

Psychologic: Depression, Anxiety, Other ____ _____

Illness, Injuries, Surgeries, Hospitalizations: _____ _____

REPRODUCTIVE HISTORY:

Are you currently sexually active? ___Yes ___No

Do you consider yourself at risk for any sexually transmitted infections?_____

Have you undergone any sexual reassignment surgery? ___ Yes ___ No

If yes please list _____

IF APPLICIBLE: ☐ N/A

Do you have a current method of Birth Control?_____

_____

How long have you used?_____ Problems?_____

_____

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. History of uterine abnormality, fibroid, infection or surgery ___Yes ___No

Comments, including dates and treatment_____

_____

_____

3. Spotting or bleeding since your last period ___Yes ___No

Do you have regular periods? ___Yes ___No 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

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

Ectopic# ____ Cesarean# ____ Multiple births____

Deceased children/cause_____

Date last pregnancy ended (regardless of how ended)_____

Dates and complications, if any, of pregnancies_____

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 specific, signed consent.