**MY MEDICAL HISTORY**

**FULL NAME**: **DATE OF BIRTH**:

**ADDRESS**:

**Cell Phone Number**:  **Other**:

**CONTACT PERSONS**: Name, Relationship, and best phone number:

Please indicate if any of these people have your power of attorney for healthcare decisions

Primary:

 Alternate:

**Name and phone number of your primary medical care provider**:

**Medication Allergies or intolerances**, and list reaction to each:

**Your Current Medications**, including **all** over-the-counter and herbals, name, dose, frequency:

**List all your active or chronic medical problems**:

**List all surgical procedures done since 1/1/2020**:

**Do you have any implanted devices or use CPAP?**; Please specify:

**List all travel outside Montana since 3/1/20**:

**Please list any other information you think we need to know:**

Please place this either on your refrigerator door or in an obvious place on your kitchen counter. If you have a living will or other advance directive not on file at Bozeman Health, please attach a copy by paper clip to this document. If you have a POLST (Montana Provider Orders for Life-Sustaining Treatment) please attach the original to this document by paper clip.