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? ____yes ____no; Please Specify:
_____
_____
List all travel outside Montana since 3/1/20: _____
_____
List any other information you think we need to know: _____
_____

Please print your answers clearly and 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.