PROVIDENCE
Medical Group
Women's Care and
Family Wellness

1211 S Reserve Street, Suite 101 Missoula, MT
Phone: #406-327-3057
Fax: #406-327-3231
Hours: 8 a.m.-5 p.m. Monday-Friday

We're happy to welcome you to Women's Care & Family Wellness! We'd like to share some information with you about our clinic and your upcoming visit. ***Please note we are a fragrance free office*; several of our patients and staff members have extreme sensitivities to fragrances. Be sure to avoid perfumes, scented body wash, lotions and hair products the day of your appointment or you may be asked to reschedule.***

Our Promise to You

Women's Care & Family Wellness is a Patient-Centered Medical Home, a unique clinic model that ensures:

- **A patient-centered approach** to your care designed to meet your individual needs and preferences
- **Coordinated care** by a team of experts working together to facilitate the right care for you, at the right time
- **Evidence-based care,** along with tools and support to manage your health care goals
- **Easy access** to your medical record and care team

Learn more about the Patient-Centered Medical Home by picking up a brochure in our clinic or visit our website at Montana.Providence.org\Clinics.

We Need Your Help

As a reminder, please complete ALL paperwork and return in the self-addressed envelope so we can get your appointment scheduled with your provider_____________________.

Please do the following prior to your appointment:

- ☐ **Plan to arrive at least 15 minutes early** to your appointment to ensure all documentation can be completed and we can stay on schedule for the benefit of all patients.
  - **Your appointment may need to be rescheduled if you do not arrive on time.**
  - **Fill out the enclosed paperwork, in advance, to the address listed above.**
- ☐ **Bring the following additional information with you:**
  - ☐ Photo ID
  - ☐ Insurance card(s)
  - ☐ Co-payment that may be due at time of service
  - ☐ Medical records from previous providers (these may also be mailed to us in advance)
  - ☐ Current list of medications, including supplements*

    **Note*: If you are currently taking routine prescription pain medications, please know that we are not a specialty pain medicine clinic and we do not routinely prescribe narcotic medications.*

We Are Here for You

Please feel free to call us at 406-327-3057 with any questions. If you need medical assistance prior to your next scheduled appointment, please contact our office and we will assist you in finding the best care option for your condition.

We look forward to seeing you soon!

CREATIVE * INTEGRATIVE * UNIQUE

PROVIDENCE Medical Group
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First Name:	MI:	Last Name:	
Date of Birth:	Social Security Number:		M F
Street Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Email:	
Race/Ethnicity: White Hispanic African American Asian Native American Other ____________		**Marital Status:** Single Married Divorced Widow Legally Separated Significant Other	
Religion:	Who is your Primary Care Provider?		

EMPLOYMENT INFORMATION
If patient is a minor, please fill in with parent's information

Employer:	If retired, date of retirement:
Address:	Phone:
Occupation:	

RESPONSIBLE PARTY FOR PATIENT (GUARANTOR) (check box if same as above) ☐

First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip:
Home/Cell Phone:	Work Phone:		
Date of Birth:	Social Security Number:		
Relationship to Patient: Self Spouse Parent Other (specify)			

Emergency Contact

Name:	Phone:
Relationship to Patient:	
Do you have (Please circle): Living Will Advanced Directive POLST Five Wishes Durable Power of Attorney	

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Reason for your visit with this provider: ____

CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS OR *Attach List of Medications, Vitamins, Supplements*

(Please list specific dosages and instructions on how each medication is taken)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Pharmacy of Choice (and location):____

Allergies/Reactions (Please list medications and specify type of reaction)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Other Current Medical Providers: (Please list name and specialty)

____
____

PERSONAL MEDICAL HISTORY

(Please list condition and approximate date of diagnosis)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PERSONAL SURGICAL HISTORY

(Please **note year** of surgical procedure or hospitalization. Indicate Right or Left; knee, shoulder, etc.)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Heart Surgery
- ☐ Gallbladder removal
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-section #______
- ☐ Eye Surgery
- ☐ Hernia Surgery
- ☐ Hysterectomy
  - ☐ Ovaries kept ☐ Ovaries removed
- ☐ Joint Replacement
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ OTHER _____________
- ☐ OTHER _____________

SOCIAL HISTORY

Who lives in your home? ____________
____

Education (level completed):_________

Exercise

How Often? ______________________

What Type? ______________________

Are you sexually active? YES NO

If sexually active: Men, Women, or Both

Do you feel safe in your current relationship and living situation? YES NO

Smoking or Tobacco Use (circle one):

Former Current Never Year quit _______

Number of years you used tobacco __________

Number of packs/day: __________________

Exposure to second-hand smoke: ___________

Alcohol

☐ Yes ☐ No

How many drinks per week? __________

Drug Use (Non-prescribed)

Do you use any of the following?

☐ Marijuana ☐ Amphetamines ☐ Narcotics
☐ Cocaine ☐ Heroine ☐ Anti-Anxiety
☐ Barbiturates ☐ Inhalants

FAMILY HISTORY

Relationship & Name	Current Age	Age at Death	Arthritis	Asthma	Birth defects	Cancer (Type)	COPD	Depression	Diabetes	Premature Death	Hearing loss	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Learning Disabilities	Mental Illness	Miscarriages	Stroke	Substance Abuse	Vision Loss	OTHER
Mother																						
Father																						
Brother																						
Brother																						
Sister																						
Sister																						
Child																						
Child																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
OTHER ___________																						
OTHER ___________																						

HEALTH MAINTENANCE

Have you had a colonoscopy? ☐ Yes ☐ No
If yes: Date_________________ Location: ____________________

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
If yes (which one): ______________________ Date: ____________

Current form of contraception (birth control): ___________________

IMMUNIZATIONS
(Please mark the date of your last immunization)

TDaP/Tetanus: _____/_____/_____
Shingles/Zoster: _____/_____/_____
HPV/Gardasil: _____/_____/_____
Pneumonia: _____/_____/_____
Influenza: _____/_____/_____

Females Only
Date of Last Pap smear: _____________ Result: _________________Where:_________________
Have you ever had an abnormal pap? ☐ YES ☐ NO Where: ______________
Number of Pregnancies________
Number of Live Births_________ Miscarriages________
Stillbirths________ Abortions________
Date of last mammogram: ______________ Result: _______________ Where: ____________________
Date of last bone density scan (DEXA): __________ Result__________ Where: _____________________

****Please be sure to state where the last tests were run so we can obtain records for your appointment****