MONTANO WELLNESS LLC

Internal Medicine

160 West Street, Suite 1A
Cromwell, CT 06416
P: (860) 632-0144
F: (860) 632-7882

Dear Patient:

Welcome to Montano Wellness LLC, the office of Dr. C. Brendan Montano. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice, as well as instructions on completion of our new patient packet.

At Montano Wellness LLC, we practice preventative medicine as well as caring for your chronic and acute medical needs. Our practice philosophy is to try for early detection, early intervention and prevention. Regularly scheduled office visits allow us to better assist you in identifying and managing any chronic health problems you may have. We believe this is in your short and long-term best interest. Being proactive about your health care can help us prevent and/or prolong the onset of future health problems as you age. We firmly believe, and our experience has shown it to be true, that those patients who are consistent in keeping their appointments have fewer episodes of acute illness, difficulty with unstable chronic illnesses, and generally continue to enjoy better health overall.

Included with this letter is our new patient packet that we ask be completed prior to your first appointment with us to ensure a timely visit. Please complete to the best of your ability: the medical history questionnaire, your demographic information, and the screening questionnaires. A HIPPA privacy and release of information authorization will be signed upon arrival for your first visit. To add other individuals to your HIPPA authorization, please request an additional form.

We utilize an automatic calling system that will call you 48 hours in advance of your appointment, as a reminder. Please bring your health insurance cards, driver's license or photo ID, and a list of your current medications to this visit. If you have any questions or concerns, please do not hesitate to contact our office.

Thank you for allowing us to assist you with your health care needs.

Sincerely,

Montano Wellness LLC

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DEMOGRAPHIC INFORMATION						
Name:						
	First		Middle		Last	
Address:						
	Street Address					
	City		State		ZIP	
Date of Birth		SSN		Gender	M F	

CONTACT INFORMATION			
Home Phone		Email Address	
Cell Phone		Emergency Contact Name	
Work Phone		Emergency Contact Number	
□ I would like to receive text message reminders for appointments and balances			

MEDICAL INFORMATION	
Preferred Pharmacy	
Preferred Laboratory	
Preferred Network	

MEDICAL QUESTIONNAIRE

Name _____ Age _____ Single / Married / Divorced / Widow(er) _____ Date _____

Occupation _____ All previous occupations _____

Birth Place _____ Birthdate _____ List all States in which you have lived _____

Education _____ years High School _____ years College _____ years Post Grad

Date of last physical examination

Please list all Symptoms

1. _____
2. _____
3. _____
4. _____
5. _____

Routine check-up—no symptoms ☐

P.I. Please do not write in this space

	If Living		If Deceased	
	Age	Health	Age of death	Cause
Father				
Mother				
Brother or Sister 1.				
2.				
3.				
4.				
5.				
Husband or Wife				
Son or Daugher 1.				
2.				
3.				
4.				
5.				
6.				

Has any blood relative ever had	Please encircle yes or no		Who
Cancer	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Heart Trouble	Yes	No	
High blood pressure	Yes	No	
Stroke	Yes	No	
Epilepsy	Yes	No	
Insanity	Yes	No	
Suicide	Yes	No	

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY

ILLNESSES Have you ever had

PLEASE ENCIRCLE ALL ANSWERS

Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Scarlet Fever or Scarlentina	Yes	No
Diptheria	Yes	No
Smallpox	Yes	No
Pneumonia	Yes	No
Influenza	Yes	No
Pleurisy	Yes	No
Rheumatic Fever or Heart Disease	Yes	No
Arthritis or Rheumatism	Yes	No
Any Bone or Joint Disease	Yes	No
Neuritis or Neuralgia	Yes	No
Bursitis, Sciatica or Lumbago	Yes	No
Polio or Meningitis	Yes	No
Nephritis	Yes	No
Gonorrhea or Syphilis	Yes	No
Gallbaldder Disease	Yes	No
Anemia	Yes	No
Jaundice	Yes	No
Bladder Disease	Yes	No
Epilepsy	Yes	No
Migraine Headaches	Yes	No
Tuberculosis	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
High or Low Blood Pressure	Yes	No
Colitis or Other Bowel Disease	Yes	No
Hemorrhoids or any Rectal Disease	Yes	No
Nervous Breakdown	Yes	No
Food, Chemical or Drug Poisoning	Yes	No
Hayfever or Asthma	Yes	No
Hives or Eczema	Yes	No
Frequent Infections or Boils	Yes	No
Any Other Disease	Yes	No

ALLERGIES Are you allergic to

Penicillin or Sulfa	Yes	No
Aspirin, Codeine or Morphine	Yes	No
Mycins or other Antibiotics	Yes	No
Merthiolate or Mercurochrome	Yes	No
Any Other Drug	Yes	No
Any Foods	Yes	No
Adhesive Tape	Yes	No
Nail Polish or Other Cosmetics	Yes	No
Tetanus Antitoxim or Serums	Yes	No

INJURIES Have you had any

Broken or Cracked Bones	Yes	No
Sprains	Yes	No
Lacerations	Yes	No
Dislocations	Yes	No
Concussions or Head Injuries	Yes	No
Ever Been Knocked Unconscious	Yes	No

WEIGHT now _____ one year ago _____

Maximum _____ when _____

TRANSFUSIONS Have you ever had

Blood or Plasma Transfusion	Yes	No

SURGERY Have you had

Tonsillectomy	Yes	No
Appendectomy	Yes	No
Any Other Operation	Yes	No
Type _____ Year _____		
Type _____ Year _____		
Type _____ Year _____		

Have you ever been advised to have any surgical operation which has not been done — Yes No

Have you been hospitalized for any illness — Yes No

Give Details:

(* Please complete other side *)

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or Severe Headaches ____ Yes No
Fainting Spells ____ Yes No
Dissiness on change of position ____ Yes No
Unconscious Spells ____ Yes No
Blurred Vision ____ Yes No
Double vision ____ Yes No
Spots before eyes ____ Yes No
Infected Eyes ____ Yes No
Pain Behind Eyes ____ Yes No
Any changes in vision ____ Yes No
Do you wear glasses ____ Yes No
When were they last checked ____
Earaches ____ Yes No
Discharge from ears ____ Yes No
Ringing in ears ____ Yes No
Decrease in hearing ____ Yes No
Recurrent nose bleeds ____ Yes No
Recurrent head colds ____ Yes No
Sinus trouble ____ Yes No
Hay Fever ____ Yes No
Strange persistant odors ____ Yes No
Strange taste or loss in taste ____ Yes No
Persistent hoarseness ____ Yes No
Difficulty swallowing ____ Yes No
Enlarged Glands ____ Yes No
Recurrent sore throats ____ Yes No
Recurrent sores in mouth ____ Yes No
Soreness or bleeding of gums on brushing ____ Yes No
Chest pain ____ Yes No
Angina Pectoris ____ Yes No
Coughed up blood ____ Yes No
Pain in arm(s) ____ Yes No
Night Sweats ____ Yes No
Chronic or frequent cough ____ Yes No
Chronic or frequent cough on laying down ____ Yes No
Wake up night short of breath ____ Yes No
How many bed pillows do you use ____
Shortness of breath on:
Walking several blocks ____ Yes No
One flight of stairs ____ Yes No
On laying down ____ Yes No
Purple lips or fingers ____ Yes No
Palpitations or fluttering of heart ____ Yes No
High Blood Pressure ____ Yes No
Swelling of hands, feet or ankles ____ Yes No
At what time of day ____
Leg cramps on walking at night ____ Yes No
Enlarged veins in legs ____ Yes No
Recurrent stomach pains ____ Yes No
Belching or heartburn ____ Yes No
Relieved by food or medication ____ Yes No
Apetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting ____ Yes No
Vomited blood ____ Yes No
Avoid some foods ____ Yes No
What kinds ____
Avoid spices ____ Yes No
Abdominal cramping ____ Yes No
Color of bowel movement ____
Any blood in BM ____ Yes No
Rectal pain with bowel movement ____ Yes No

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Changes in size, shape or texture of BM ____ Yes No
Describe ____
Pain on urinating ____ Yes No
Difficulty in starting urination ____ Yes No
Do you get up at night to urinate ____ Yes No
How many times ____
Urinate more than before ____ Yes No
Urinate less than before ____ Yes No
Any blood in urine ____ Yes No
How many times a day do you urinate ____
Full feeling of bladder but only small amount of urine ____ Yes No

Lose urine on coughing or sneezing ____ Yes No
Discharge from penis ____ Yes No
Recurrent back pains ____ Yes No
Backaches ____ Yes No
Joint pains ____ Yes No
Swelling of any joints ____ Yes No
Redness or heat of any joint ____ Yes No
Tingling or weakness of hands or feet ____ Yes No
Muscle spasms ____ Yes No
Loss or change in sensation of hands and feet ____ Yes No
Trembling of any extremity ____ Yes No
Growth in neck or throat ____ Yes No
Hot flashes ____ Yes No
Tiredness without apparent reason ____ Yes No
Brittleness of nails ____ Yes No
Dryness of skin ____ Yes No
Easy bruising ____ Yes No
Inability to stand heat ____ Yes No
Inability to stand cold ____ Yes No
Change in hair texture ____ Yes No
Change in skin texture ____ Yes No
Any skin rash ____ Yes No
X-RAYS: Have you ever had X-rays of
Chest ____ Yes No
Stomach or colon ____ Yes No
Gallbladder ____ Yes No
Extremities ____ Yes No
Back ____ Yes No
Teeth ____ Yes No
Other ____ Yes No
EKG: Have you ever had an electrocardiogram ____ Yes No
IMMUNIZATIONS: Have you had
Smallpox vaccination within last 7 years ____ Yes No
Tetanus shots (not antitoxin which only last 2 weeks) ____ Yes No
Polio shots within last 2 years ____ Yes No
DRUGS: Laxatives never ☐ occ ☐ freq ☐ daily ☐
Vitamins never ☐ occ ☐ freq ☐ daily ☐
Sedatives never ☐ occ ☐ freq ☐ daily ☐
Tranquilizers never ☐ occ ☐ freq ☐ daily ☐
Sleeping pills,etc. never ☐ occ ☐ freq ☐ daily ☐
Aspirin, etc. never ☐ occ ☐ freq ☐ daily ☐
Cortisone Acht never ☐ occ ☐ freq ☐ daily ☐
Thyroid never ☐ yes, in past, none now ☐
daily ☐ now on ____ gr daily
Vitamins never ☐ occ ☐ freq ☐ daily ☐
Have you ever been treated for drug habits ____ Yes No
Have you ever taken Insulin or tablets for diabetes ____ Yes No
Have you ever taken Hormone tablets or injections ____ Yes No
SEX: Entirely satisfactory ____ Yes No

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset: ____
Regular?: Yes ☐ No ☐ Varies ☐
Cycle: ____ days (from start to start)
Flow: Heavy ☐ Medium ☐ Light ☐
Number of pads used per period ____
Any clots passed ____ Yes No
Pain or cramps ____ Yes No
Date of last period ____
Date of last pelvic exam ____
Date of last pap test ____
Results: Neg ☐ Pos ☐
Any discharge from vagina ____ Yes No
If so, color ____
Amount ____
Any itching of vaginal area ____ Yes No
Do you take birth control pills ____ Yes No
How long have you taken them ____
Pregnancies:
How many children born alive ____
How many still births ____
How many premature births ____
How many Cesarean Sections ____
How many miscarriages ____
Any complications with pregnancy ____ Yes No
Describe ____
Other ____

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MEDICAL RECORD RELEASE REQUEST (MEDICAL)

PATIENT NAME: _____ Date of Birth _____

Address: _____

Social Security # _____ Phone # _____

The following person or facility is authorized to provide copies of the patient's identifiable health information:

RELEASE FROM: NAME: _____

Address: _____

Phone: _____ Fax _____

SEND TO: NAME: **Montano Wellness LLC**

Address: **160 West Street, Suite 1A, Cromwell, CT 06416**

Phone: **(860) 632-0144** Fax **(860) 632-7882**

Purpose for releasing the information:
( ) Moving Away from Area ( ) Transfer of Care ( ) At request of Patient ( ) For Patient Care

Describe the information that is to be released:
( ) Office / treatment notes ( ) Lab Reports ( ) X-ray / CT reports ( ) EKG
( ) Other (please specify): _____

Indicate the dates of service that is to be released:
( ) Entire medical records for services rendered at this office.
( ) Last office visit, laboratory, and/or x-ray test results
( ) Other (please specify): _____

PATIENT SIGNATURE: _____ DATE: _____

Or Legal Representative of Patient: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Mood Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Are you living with Adult ADHD?

The questions below can help you find out.

Many adults have been living with Adult Attention-Deficit/Hyperactivity Disorder (Adult ADHD) and don't recognize it. Why? Because its symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD – a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. **An accurate diagnosis can only be made through a clinical evaluation.** Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD, please discuss your concerns with your physician.

This Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener is intended for people aged 18 years or older.

Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener

from WHO Composite International Diagnostic Interview

Date

Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Add the number of checkmarks that appear in the darkly shaded area. Four (4) or more checkmarks indicate that your symptoms may be consistent with Adult ADHD. It may be beneficial for you to talk with your healthcare provider about an evaluation.

The 6-question Adult Self-Report Scale-Version1.1 (ASRS-V1.1) Screener is a subset of the WHO's 18-question Adult ADHD Self-Report Scale-Version1.1 (Adult ASRS-V1.1) Symptom Checklist.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.