Riverbend Health Care

Patient Name: DOB: Date:

MEDICAL & SURGICAL HISTORY

Please list any health problems that a doctor has diagnosed you with (include name of Dr, yr diagnosed, if known)

_____ _____
_____ _____
_____ _____

Have you ever been hospitalized (overnight)? Yes No If yes, please list reason(s) & date(s):

_____ _____
_____ _____

Have you ever had any type of surgery? Yes No If yes, please list surgery type(s), Dr(s) &date(s):

_____ _____
_____ _____

SOCIAL HISTORY & HEALTH RISK ASSESSMENT

How many people live in your household?		Do you use marijuana?	□ Yes □ No
Do you have any pets?	□ Yes □ No	Are you currently on a diet?	□ Yes □ No
Do you drink caffeine (coffee, tea, soda)?	□ Yes □ No	Do you exercise regularly?	□ Yes □ No
If yes, how many cups/cans per day?		Do you wear sunscreen?	□ Yes □ No
Do you use tobacco (cigarettes/cigars/pipe)?	□ Yes □ No	Do you wear seatbelts?	□ Yes □ No
If yes, how many per day? _____		Does your home have a smoke detector?	□ Yes □ No
Do you drink alcohol?	□ Yes □ No	Does your home contain a gun?	□ Yes □ No
If yes, how often do you drink?		Do you have any religious/cultural beliefs	□ Yes □ No
□ Daily □ Once a week □ Once a month □ Rarely		that could affect your medical care?	
Have you ever used recreational/street drugs?	□ Yes □ No	Do you have an advanced directive/living will?	□ Yes □ No

FAMILY HISTORY

Is your mother alive or deceased? Alive □ Deceased Current Age or Age at Death _____
List any medical problems your mother has/had: _____
_____

Is your father alive or deceased? Alive □ Deceased Current Age or Age at Death _____
List any medical problems your father has/had: _____
_____

How many brothers do you have? _____
How many sisters do you have? _____
How many children do you have? _____

Please check if any of the following illnesses/conditions run in your family:

Alcohol or Drug Abuse Bleeding Disorder Cancer Diabetes Genetic Disorder Tuberculosis
Heart Disease (CAD, Heart Attack) High Blood Pressure Heart Failure High Cholesterol Stroke
Kidney Disease Liver Disease Anxiety or Depression Rheumatoid Arthritis Lupus Osteoarthritis
Other _____

List of Current Medications: List of Allergies:

Medication: _____ Dose: _____ _____
Medication: _____ Dose: _____ _____
Medication: _____ Dose: _____ _____
Medication: _____ Dose: _____ _____
Medication: _____ Dose: _____ _____

List of Doctors/Specialists Seen (Include Dr. Name, Phone #, and Reason Seen):_____
_____

Patient Name: **DOB:** **Date:**

REVIEW OF SYSTEMS *Please circle yes or no to indicate if you have the following symptoms*

General
Weight change in last year… yes/no
Fever or chills …….. yes/no
Night Sweats……. yes/no
Trouble Sleeping……yes/no

Musculoskeletal
Painful or swollen joints…… yes/no
Stiffness……. yes/no
Back pain…….. yes/no
History of arthritis…… yes/no
History of gout…….. yes/no
History of fractures……... yes/no
History of osteoporosis……. yes/no

ENT (Ears/Nose/Throat)
Ear Pain……. yes/no
Hearing problems/hearing aid yes/no
Ringing in ears ……..yes/no
Sinus problems/postnasal drip yes/no
Hay fever …….. yes/no
Nose bleeds …….. yes/no
Do you wear dentures? ……. yes/no
Throat irritation or hoarseness yes/no
Neck swelling or lumps …… yes/no

Genito-Urinary
Painful or burning urination.. yes/no
Difficult urination (weak) … yes/no
Incontinence(can't hold urine)yes/no
Urine leakage with coughing yes/no
Excessive urination/urgency yes/no
Blood in urine ……. yes/no
History of urinary tract infection yes/no
History of kidney stones ….. yes/no
Sexually transmitted disease yes/no
Sexually active …… yes/no
Have more than one partner yes/no
Sexual concerns/impotence yes/no
Do you use condoms? ……. yes/no
Vaginal or Penis discharge... yes/no
Prostate problems(men only) yes/no
Urination at night …… yes/no
Difficulty with erection (men) yes/no

Hematology/Oncology
Easy bruising ……. yes/no
Bleeding problems ……... yes/no
History of anemia …… yes/no
History of leukemia ……. yes/no
History of blood transfusion yes/no
History of cancer/malignancy yes/no

Eyes
Change in vision or double vision…. yes/no
Glasses/Contact lenses…….. yes/no
History of cataracts or glaucoma….. yes/no
Dry eyes…… yes/no

Neurological
Weakness of arms or legs..... …… yes/no
Numbness(loss of feeling)/Tingling yes/no
Trouble walking or talking……. yes/no
History of seizures…….. yes/no
History of severe head trauma…… yes/no
Frequent headaches/migraines…… yes/no

Lungs
Shortness of breath at rest……. yes/no
Shortness of breath with activity…... yes/no
Cough ……yes/no
Cough with blood ……. yes/no
Wheezing …….. yes/no
Do you snore? ……yes/no
History of asthma or emphysema….. yes/no
History of bronchitis or pneumonia.. yes/no
History of tuberculosis ……. yes/no
Date of last TB/PPD testing: _____

Reproductive (Women Only)
Breast pain, disease, or lumps …….. yes/no
Irregular menstrual periods …….. yes/no
Painful menstrual periods …… yes/no
Heavy menstrual periods ……. yes/no
Premenstrual syndrome (PMS) …… yes/no
Date of last menstrual period _____
Age when menstruation started _____
Age of onset of menopause _____
Number of pregnancies _____
Number of births _____
Number of miscarriages/abortions _____
Date of last mammogram _____
Date of last pelvic exam/PAP Smear _____
OB/GYN name & number_____
_____

Psychiatric
Do you feel sad or depressed? ……. yes/no
Do you have anxious feeling? ……. yes/no
Eating disorders (anorexia/bulimia) yes/no
History of suicide attempt …… yes/no
Physical, verbal, or sexual abuse …. yes/no
Anxiety …… yes/no

Skin
Rashes or itching……yes/no
History of eczema (dry skin)..yes/no
Rash with sun exposure……. yes/no
Fingers/toes turn color in cold yes/no
Change in mole…….. yes/no

Endocrine
Fatigue……yes/no
Heat or cold intolerance…….yes/no
History of Thyroid Disease…yes/no
Excessive thirst…….. yes/no
History of diabetes…….yes/no
Low or high blood pressure... yes/no

Stomach/Intestines
Nausea/Vomiting …….. yes/no
Heartburn/Indigestion…… yes/no
Abdominal Pain …… yes/no
Constipation or diarrhea ….. yes/no
Bloody or black stool ……yes/no
Difficulty swallowing ……... yes/no
History of peptic ulcers …… yes/no
History of gallstones ……. yes/no
History of liver disease ……. yes/no
History of jaundice ……... yes/no
Date of last colonoscopy _____
Doctor name & number _____
_____

Heart
Chest pain/tightness at rest … yes/no
Chest pain/tightness with activity yes/no
Skipped heart beats/palpitations yes/no
Heart murmur …… yes/no
Heart valve problems …….. yes/no
High blood pressure …… yes/no
High cholesterol …….. yes/no
Wake up with trouble breathing? yes/no
Use more than 2 pillows at night?yes/no
Pain in legs with walking …. yes/no
Swelling of legs or ankles …. yes/no
Heart attack or heart surgery yes/no
Rheumatic fever ……. yes/no
History of blood clots …… yes/no

Immunizations
Date of last tetanus _____
Date of last flu vaccine_____
Date of last pneumonia vaccine (pneumovax)_____

Signature _____ **Date** _____