Name:___________________________FIN#:______________
Attending Physician:_______________MR#_______________
(for office use only)

Name: ____ Date: ______________________

Primary Care Physician:____________________ Phone: (____)__________ Hospital Affiliation:______________

Referring Physician:_______________________ Phone: (____)__________ Hospital Affiliation:______________

Pharmacy: ___________________ Address: _____________________________________ Phone: (____)___________

What is the reason for your appointment____

What are your goals for this visit?____

If you have a form with your wishes for CPR or other life sustaining treatment, please bring it to your appointment.

PAIN:

Do you have pain? YES NO

If YES:

What makes it better?__________________________________

What makes it worse?__________________________________

List 3 activities that are limited by your pain:

1)

2)

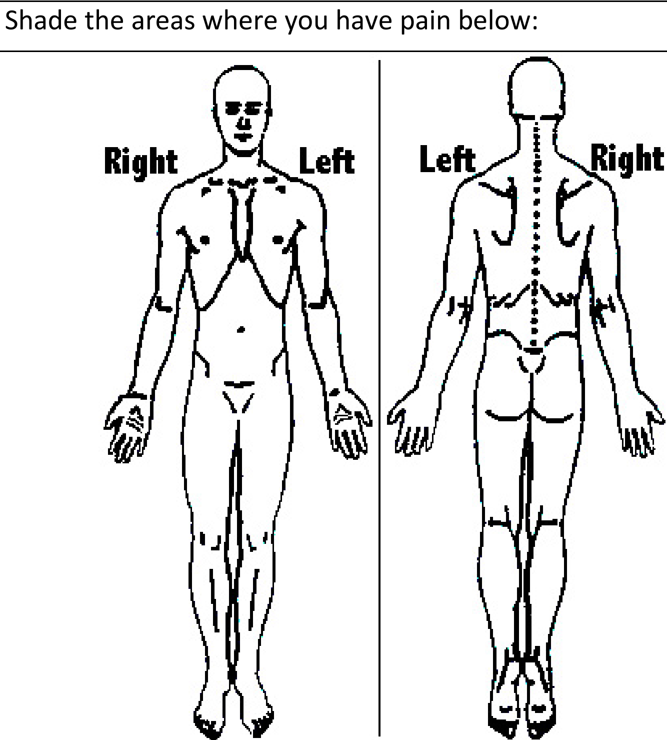
3)

Please circle a number below to indicate the level of pain you currently have.

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Shade the areas where you have pain below:



PAST MEDICAL HISTORY:

Have you ever been diagnosed as having the following conditions:		
YES	NO	Cancer: What type?__________________
YES	NO	Heart problems What type?__________________
YES	NO	High blood pressure
YES	NO	Circulation problems
YES	NO	Asthma
YES	NO	Chronic Obstructive Pulmonary Disease
YES	NO	Chemical dependency (e.g., alcoholism)
YES	NO	Thyroid problems
YES	NO	Diabetes
YES	NO	Multiple sclerosis
YES	NO	Rheumatoid arthritis
YES	NO	Other arthritic conditions
YES	NO	Fractures
YES	NO	Depression/Anxiety
YES	NO	Hepatitis
YES	NO	Tuberculosis
YES	NO	Stroke
YES	NO	Kidney disease
YES	NO	Blood clots
YES	NO	Osteoporosis
YES	NO	Stomach ulcers
YES	NO	Other: ______________________

Please continue on the next page

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Please list any surgeries or other conditions for which
you have been hospitalized, including date and reason for the surgery or hospitalization:

____

____

____

ALLERGIES:

List any allergies to medications:_______________________________________

Are you latex sensitive? YES NO

FAMILY HISTORY:

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

YES NO	Diabetes	YES NO	Cancer
YES NO	Heart Disease	YES NO	Depression
YES NO	High Blood Pressure	YES NO	Kidney Disease
YES NO	Stroke	YES NO	Neurologic Condition
YES NO	Inflammatory Arthritis (Rheumatoid, Ankylosing)		

DAILY ACTIVITIES/HEALTH HABITS:

Have you ever been diagnosed with any of the following (circle): MRSA VRE Cdiff Tuberculosis

Do you use tobacco? YES NO Packs/day ________ # years____ If quit, when? _________

How many alcoholic beverages do you drink per week? ______________

Do you use street drugs? YES NO If yes, which ones?___________________________

How many caffeinated beverages do you drink per day? ❐0-1 ❐2-4 ❐5 or greater _

What is your current occupation? _________________________________

Current employment status? ❐Full Time ❐Part Time ❐Retired ❐On Disability Leave ❐Unemployed

In what leisure activities, hobbies and/or exercise regimens do you participate? _____________________________

____

Please check the box of any of the following symptoms/signs that are currently occurring:

	Weight loss/gain		Difficulty breathing / shortness of breath		Skin rash
	Nausea		Regular/persistent cough		Excessive bleeding
	Vomiting		Recent infection		Easy bruising
	Dizziness/lightheadedness		Diarrhea		Unusual joint/muscle swelling
	Fatigue		Constipation		General arm/leg swelling
	Unusual weakness		Bowel incontinence		Loss of sensation
	Fever/chills/sweats		Blood in stools		Hearing problems
	Numbness or tingling		Post-menopause		Difficulty speaking
	Tremors		Problems urinating		Difficulty swallowing
	Seizures		Urinary incontinence		Stress at home or work
	Night sweats		Urinary urgency		Double vision
	Chest pain		Urinary frequency		Loss of vision
	Heart racing in your chest		Urinary retention requiring catheterization		Unusual eye redness
	Abdominal pain		Blood in the urine		Problems sleeping
	Heartburn/indigestion		Pregnant or think you might be pregnant		Sexual difficulties
	I do not have any of the signs or symptoms listed above.				

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Please do not complete if you have submitted a copy of your medication list within the past month at any RIC location.

MEDICATION LIST:

Please list your medications including supplements and vitamins:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
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20.

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