

Rapides Regional Physician Group
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Patient History Form

Date of first appointment ____ / ____ / ____ Time of appointment: _____ Birthplace _____

Name: _____ Birthdate: ____ / ____ / ____
Last First Middle Initial (Maiden)

Address: _____ Age: _____ Sex: Female Male
Street Apt.#

Telephone: Home (____) _____
Work (____) _____

Marital Status: Never Married Married Divorce Separated Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illness _____

Ethnic Group: Asian Black Hispanic White Other

Please check if this questionnaire is completed entirely by patient or with help from (home) _____

Please indicate the name, address and phone number of someone who lives at a different address from you, and who will be likely to know your whereabouts if we are unable to reach you. Relationship: _____

Name: _____ Address: _____

City, State, Zip: _____ Telephone Number: _____

**What is your current occupation?
(If you are not working now, what
was your past occupation?)**

At this time, are you? (Please check (✓) all that apply)

_____ Working full time _____ Retired
_____ Working part time _____ Student
_____ Homemaker, full time _____ Disabled
_____ Other _____

How many other people live at home with you? (Please check (✓) who lives with you.)

_____ Spouse/partner _____ Parents _____ Sons or daughters _____ I live alone
_____ Other (describe) _____

How many years of school have you completed? (Please circle the number of years of school.)

1 2 3 4 5 6 7 8 9 11 12 13 14 15 16

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Address: _____ Phone: _____

Do you have an orthopedic surgeon? Yes No If yes, please name: _____

Describe, briefly, your present symptoms: _____

Date symptoms began (approximate): _____ Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; **medications will be listed later.**)

Please list the names of other practitioners you have seen for this problem: _____

Reviewed by: _____

Date: _____

Patient Name: _____

Over the last 6 months, have you had:

- | | | | | | |
|----------|-----------|---------------------------|----------|-----------|--|
| _____ No | _____ Yes | An operation | _____ No | _____ Yes | Change of address |
| _____ No | _____ Yes | Inpatient Hospitalization | _____ No | _____ Yes | Change of marital status |
| _____ No | _____ Yes | A new illness | _____ No | _____ Yes | Quit work, retired, change job or duties |
| _____ No | _____ Yes | An important new symptom | _____ No | _____ Yes | Change of primary care or other doctor |

(Please explain any "Yes" answers below, or write anything else you may think the doctor should know.)

Please list below any medications which you cannot take because you are allergic to them:

Please list below anything else (grass, molds, pollens, etc.) you might be allergic to:

Please write below all the drugs or medicines you have taken over the last two weeks for any condition.

(include aspirin, birth control pills, and any drug or medicine *with* or *without* prescription. If additional space is needed list on separate page.)

NAME OF DRUG OR MEDICINE	DOSE (IF KNOWN)	How many per day or week?	NAME OF DRUG OR MEDICINE	DOSE (IF KNOWN)	How many per day or week?
1. _____	_____	_____	8. _____	_____	_____
2. _____	_____	_____	9. _____	_____	_____
3. _____	_____	_____	10. _____	_____	_____
4. _____	_____	_____	11. _____	_____	_____
5. _____	_____	_____	12. _____	_____	_____
6. _____	_____	_____	13. _____	_____	_____
7. _____	_____	_____	14. _____	_____	_____

Do any of the above drugs cause you side effects? Yes No (If "Yes", please write the drug(s) and the side effects below)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Circle any you have taken in the past.					
Ansoid (flurbiprofen)	Arthrotec (diclofenac+misoprostil)	Aspirin (including coated aspirin)	Celebrex (celecoxib)	Clinorill (sullindac)	Daypro (oxoprozin)
Disalcid (saisalate)	Dolobid (difunisal)	Feidene (piroxicom)	Indocin (indomethacin)	Lodine (atodolac)	Meciomen (meciofenamate)
Motrin/Rufen (ibuprofen)	Naifan (fenoprofen)	Noprosyn (noprofen)	Oruvail (ketoprofen)	Tolectin (tolmettin)	Trillsate (choline magnesium trisolyctc)
Vioxx (rofecoxib)	Voitaren (cliclofenac)				

Please list below all operations you have ever had: *Please check (✓) here, if none* _____.

Operation	Year	Surgeon	Hospital, City, State
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

(You may continue on a separate page)

Reviewed by: _____

Date: _____

Patient Name: _____

Please list below all major illnesses or admissions to a hospital (other than for operations):

Please check (✓) here, if none _____.

<u>Illness or reason for hospitalization</u>	<u>Year</u>	<u>Hospital, City, State</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please check (✓) either "NO" or "YES" to indicate whether or not you have any of the conditions below:
(If you answer "YES", please write AGE or YEAR when it began)

Have you had:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Age	Year	Have you had:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Age	Year
Hypertension/high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Gynecological (Female)	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Prostate (Male)	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Other Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Bronchitis or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Back or spine problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Fibromyalgia (Fibrosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Other Lung problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Anemia (Low Blood)	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Other hematologic problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Other gastrointestinal (GI) problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
Other _____ <small>Please Name</small>			_____	or _____	Severe Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	or _____
					Other _____ <small>Please Name</small>			_____	or _____

The questions below concern your family medical history:

	If Living		If Deceased	
	Age(s)	Any Major Medical Condition	Age(s) At Death	Cause(s) of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Son(s)	_____	_____	_____	_____
Daughter(s)	_____	_____	_____	_____

Any blood relative (parent, child, brother, sister, aunt uncle) with: (If "Yes" give relationship)

	No	Yes	Relation(s)	No	Yes	Relation(s)
Rheumatoid Arthritis	_____	_____	_____	_____	_____	_____
Lupus or SLE	_____	_____	_____	_____	_____	_____

Any illness which run in the family? _____

Social History

Do you drink caffeinated beverages? No Yes
Cups/Glasses per day? _____

Do you smoke? No Yes Past
(If yes, how many per week?) _____

Do you drink alcohol? No Yes
(If yes, how many per week?) _____

Has anyone ever told you to cut down on your drinking? No Yes

Do you use drugs for reasons that are not medical? No Yes
(If yes, please list) _____

Do you exercise regularly? No Yes
Type: _____
Amount per week: _____

How many hours of sleep do you get at night? _____

Reviewed by: _____ Date: _____

As you review the following list, please check any of those problems which have significantly affected you.

Please check (✓) if you have experienced any of the following over the last month:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain (>10lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (<10lbs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting of hands |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Heart pounding (palpitations) | <input type="checkbox"/> Swelling in other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression - feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety - feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain, aches, or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

Date of last Mammogram / /

Date of last Chest X-ray / /

Date of last Bone Densitometry / /

Date of last Colonoscopy / /

Date of last Cholesterol Check / /

Date of last Eye Exam / /

Date of last Tuberculosis Test / /

Date of last Pap Smear / /

Date of last PSA / /

Reviewed by: _____

Date: _____