Newborns To Geriatrics
RIVERSIDE FAMILY HEALTH PL
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MEDICAL HISTORY

Patient Name _____ **Date of Birth** _____ ☐**Male** ☐**Female**

Preferred Pharmacy Name/location/phone_____

Preferred Lab your Insurance company uses: ☐**Quest*** ☐**Lab Corp** ☐**Lab One** ☐**Wuesthoff** ☐**Health First**

*If no Lab is chosen, we will send to Quest Labs automatically.
** I understand that if my LAB DIRECTIVE is incorrect, I am financially responsible for the bill that the lab sends me. _____
Initial

Advanced Directives ☐None ☐Do Not Resuscitate ☐Durable Power of Attorney ☐Living Will ☐Healthcare Proxy
Date Reviewed:_____

Allergies: ☐None (Please list all known medication, food and environmental allergies)

Source (example, penicillin)	Reaction (example, hives)

Current Medications: ☐None **(Include vitamins, supplements, birth control pills, aspirin, eye drops,etc)** OR ATTACH MEDICATION LIST

Name Of Medication	Dose And Direction	Refill Needed?	
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No

Screening & Preventive Medicine: ☐**None** ***Indicate DATES and WHERE the tests were done.**

☐Colonoscopy	☐Cardiac Stress Test	☐Mammogram
☐Endoscopy	☐Cholesterol Blood work	☐Pap Smear
☐Prostate Exam/PSA	☐Eye Exam	☐DEXA Bone Density Scan
☐FOBT Stool test card	☐Foot Exam	☐Physical Exam

Vaccinations: ☐None

☐Flu Shot	☐Shingles Vaccine	☐Pneumonia Vaccine (x 2)	☐Tetanus – Adult Booster
☐Hepatitis B	☐PPD – TB Skin Test	Have you ever been exposed to someone with Tuberculosis? ☐Yes ☐No	

Medical Problems: ☐None (Please check any conditions you have now or in the past) **INDICATE THE YEAR OF ONSET**

_____ ☐Allergies/Excema	_____ ☐Emphysema/COPD	_____ ☐Kidney Problem	_____ ☐Mental Illness
_____ ☐Asthma	_____ ☐Gastric reflux	_____ ☐Kidney Stones	_____ ☐Dementia/Alzheimr
_____ ☐Arthritis	_____ ☐Heart Arrhythmia	_____ ☐Migraine Headaches	_____ ☐Glaucoma
_____ ☐Atrial fibrillation	_____ ☐Heart Attack	_____ ☐Seizures	_____ ☐Cataracts
_____ ☐Anxiety	_____ ☐Heart Disease	_____ ☐STDs	_____ ☐IBS/Colitis
_____ ☐Depression	_____ ☐High Cholesterol	_____ ☐Stroke	_____ ☐Incontinence
_____ ☐Diabetes	_____ ☐High Blood Pressure	_____ ☐Thyroid Disorder	_____ ☐Frequent UTIs
_____ ☐Cancer (specify type)	_____ ☐Hepatitis	_____ ☐Ulcers	_____ ☐_____
_____	_____ ☐Obesity	_____ ☐Gout	_____ ☐_____

Past Surgical History: ☐None Check if you have received the following procedures and **INDICATE THE YEAR PERFORMED**.

_____ ☐Appendectomy	_____ ☐Bladder surgery	_____ ☐Gastric bypass	_____ ☐Breast Augmentation
_____ ☐Cataract R L	_____ ☐Colostomy	_____ ☐Gallbladder	_____ ☐Breast Biopsy
_____ ☐Hemorrhoid surgery	_____ ☐Cholecystectomy	_____ ☐Sinus surgery	_____ ☐Mastectomy
_____ ☐Back surgery	_____ ☐Hernia repair	_____ ☐Tonsillectomy	_____ ☐Tubal ligation
_____ ☐Neck surgery	_____ ☐Valve repair	_____ ☐Thyroid removed	_____ ☐Hysterectomy
_____ ☐Hip replacement	_____ ☐CABG (Heart Bypass)	_____ ☐Vasectomy	_____ ☐_____
_____ ☐Knee replacement	_____ ☐Pacemaker	_____ ☐Prostate Biopsy	_____ ☐_____

Other hospitalizations (describe):

Women's Health: ☐Skip this section if male

Number of pregnancies_____ Number of Deliveries_____ C-sections_____ Miscarriages_____

Any pregnancy complications (example, pre-eclampsia) _____

Any abnormal PAP smears (explain)_____

Date of Last Menstruation_____ Date/Age First Menstruation_____

Medical Conditions Running in My Family: ☐Adopted-Unknown **M**-Mother **F**-Father **S**-Sister **B**-Brother **C**-Child **GM**-Grandmother **GF**-Grandfather

☐Alcoholism/drug addiction	☐Alzheimer/dementia	☐Arthritis	☐Asthma/Allergies
☐Blood/Clotting Disorder	☐Breast Cancer	☐Colon Cancer	☐Prostate Cancer
☐Skin cancer or melanoma	☐Uterine/Cervical cancer	☐Other Cancer	☐Chronic Lung Disorder
☐Diabetes	☐Headaches	☐Heart Disease	☐High Blood Pressure
☐High Cholesterol	☐Kidney Disease	☐Liver Disease	☐Mental Illness
☐Obesity	☐Osteoporosis	☐Seizure/Epilepsy	☐Stroke
☐Thyroid Disorder	☐Ulcer	☐_____	☐_____

Family Medical History: ☐None

Relation	Age, or if Deceased, Age at Death and Cause	Significant Health Problems or Hereditary Conditions
Father		
Mother		
Siblings		
Children		

Patient Name_____

Other Doctors or Health Care Providers: ☐None

Specialty	Name	City	Still Seeing?	
Cardiologist			☐Yes	☐No
Ob/Gyn			☐Yes	☐No
Gastroenterologist			☐Yes	☐No
Oncologist			☐Yes	☐No
Eye Doctor			☐Yes	☐No
Urologist			☐Yes	☐No
Pain Management			☐Yes	☐No
Other-			☐Yes	☐No

Social History:

Marital Status or Living Arrangement: ☐Single ☐Married ☐Partner ☐Separated/Divorced ☐Widowed		
Do you have any children: ☐No ☐Yes Number and Ages:_____		
Employment: ☐Full-time ☐Homemaker ☐Retired ☐Disabled ☐Unemployed ☐Student ☐Other: _____		
Occupation (Previous/Current):		Exposure to Hazardous Materials? ☐Yes ☐No
Tobacco Use ☐Never	☐Current ☐Former (Year Quit_____)	_____ pack(s) per day for _____ years ☐Cigarette ☐Chewing ☐Pipe ☐Cigar ☐Smokeless
Alcohol Use ☐Never	☐Current ☐Former (Year Quit_____)	_____ drink(s) per ☐Day ☐Week ☐Month ☐Year ☐Beer ☐Wine ☐Liquor ☐Other_____
Drug Use ☐Never	☐Current ☐Former (Year Quit_____)	☐Marijuana ☐Cocaine ☐Heroin ☐Prescription ☐Other_____ EVER SHARED NEEDLES? ☐Yes ☐No
Exercise ☐Never	☐Moderate but Regular ☐Vigorous ☐Occasionally	What kind?

Pediatric Patient: ☐N/A

Patient Primarily Resides with: ☐Both Parents in Same Home ☐Mother ☐Father ☐Both Parents Equal but Separate ☐Other Parents' Relationship: ☐Married ☐Divorced ☐Single ☐Separated ☐Widowed Childcare: ☐Mother ☐Father ☐Grandparent ☐Sibling ☐Nanny ☐Daycare ☐None	
Mother's Occupation	Father's Occupation
Tobacco Exposure? ☐Yes ☐No	Any Smokers in the Home? ☐Yes ☐No

Other Important Information Concerning Your Health:

_____

_____

_____

_____

Signature:_____ Date:_____