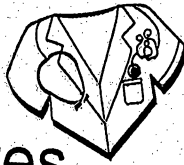


Richmond Family Medicine Associates



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Today's Date: _____ Primary Care Physician: _____ MRN: _____
Patient's Name: _____ Date of Birth: _____ Sex: M F
Preferred Pharmacy: _____ Pharmacy Telephone Number: _____

What is the reason for your visit today? _____
What medications are you currently taking? (Attach list if necessary) _____

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? Yes No If yes, what medication? _____
What type of reaction did you have to this medication? _____
Are you currently pregnant or nursing? _____

Please check any symptoms below that you are currently experiencing:

Constitutional:

- Fever/Chills
- Feeling poorly
- Feeling tired
- Recent weight gain/loss
- Night sweats

Eyes:

- Eye pain
- Red eyes/Discharge
- Vision changes
- Dry eyes
- Itchy eyes

ENT:

- Earache
- Sore throat
- Nasal congestion/discharge
- Nosebleeds
- Hoarseness
- Hearing Loss

Cardiovascular:

- Chest pain
- Irregular heart beats
- Lower extremity edema
- Leg cramps
- Pain with exercise
- Slow heart rate
- Fast heart rate

Respiratory:

- Shortness of breath
- Shortness of breath during exertion
- Cough
- Wheezing
- Shortness of breath with lying down/at night

Gastrointestinal:

- Nausea and/or Vomiting
- Abdominal pain
- Diarrhea
- Heartburn

Genitourinary:

- Trouble swallowing
- Dark or bloody stool
- Pain with urination
- Frequency/Urgency of urination
- Night time urination
- Hesitancy
- Incontinence (loss of urine control)
- Blood in urine
- Genital lesion
- Difficulty with menstrual periods (females)
- Erectile dysfunction (males)

Musculoskeletal:

- Joint pain
- Muscle pain
- Joint swelling
- Joint stiffness
- Limb pain/swelling
- Muscle cramps/weakness

Integumentary:

- Skin rash
- Itching
- Skin lesions
- Change in a mole
- Breast pain/lump
- Wound/Unusual growth on the skin

Neurological:

- Headache
- Dizziness
- Mental changes
- Fainting
- Limb weakness
- Difficulty walking
- Numbness
- Tremor
- Radiating pain

Psychiatric:

- Anxiety
- Depression
- Suicidal or homicidal thoughts
- Personality changes/Irritability
- Sleep disturbances

Endocrine:

- Excessive thirst/urination
- Drooping of eyelid
- Hot or cold intolerance
- Hair loss
- Generalized weakness

Blood/Lymph:

- Easy bruising/bleeding
- Swollen glands

Social History:

Do you use tobacco products?
 Yes No Past
Cigarettes per day? _____
How many years have or did you use tobacco? _____
Drink more than 2 alcoholic beverages per day?
 Yes No
Cups of coffee per day? _____
Use seat belt regularly?
 Yes No
Do you use drugs for reasons that are not medical? If so, please list:

(See additional questions, on back of form.)

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

- | | | | |
|-----------------------------------|---------------------|-----------------------------|----------------------|
| ADHD | COPD/ Emphysema | High Cholesterol | Rheumatoid Arthritis |
| Alcoholism | Dementia | HIV | Seizure Disorder |
| Allergies, Seasonal | Depression | Hepatitis | Sleep Apnea |
| Anemia | Diabetes: 1 or 2 | Irritable Bowel Syndrome | Stroke |
| Anxiety | Diverticulitis | Lupus | Thyroid Disorder |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot) | Liver Disease | Ulcerative Colitis |
| Arthritis | GERD (Acid Reflux) | Macular Degeneration | |
| Asthma | Glaucoma | Neuropathy | |
| Bipolar | Heart Disease | Osteopenia/Osteoporosis | |
| Bladder Problems / Incontinence | Heart Attack (MI) | Parkinson's Disease | |
| Bleeding Problems | Hiatal Hernia | Peripheral Vascular Disease | |
| Cancer: _____ | High Blood Pressure | Peptic Ulcer | |
| Headaches | Kidney Stones | Psoriasis | |
| Crohn's Disease | Kidney Disease | Pulmonary Embolism (PE) | |

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date: _____	Normal Abnormal
Mammogram	Yes/No Date: _____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date: _____	Normal Abnormal
Pap	Yes/No Date: _____	Normal Abnormal

Other medical problems not listed above:

Surgical History: Please list all prior surgeries and approximate dates performed.

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

- | | | | | |
|------------|------------------|------------------|---------------------|------------------|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

- | | | | | |
|------------|------------------|------------------|---------------------|------------------|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

SIBLINGS:

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Patient Signature: _____

Date: _____