Richmond Family Medicine Associates

312 Jason Drive, Suite 9
Richmond, KY 40475
Phone (859) 575-4075
Fax (859) 575-4126
www.richmondfamilymedicineky.com

Today's Date:_____ Primary Care Physician:_____ MRN: _____

Patient's Name:_____ Date of Birth:_____ Sex: q M q 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? q Yes q 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?
q Yes q No q Past
Cigarettes per day? _____
How many years have or did you use tobacco? _____
Drink more than 2 alcoholic beverages per day?
q Yes q No
Cups of coffee per day? _____
Use seat belt regularly?
q Yes q 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: