Richmond Family Medicine Associates

Comprehensive Care for Your Entire Family

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Patient's Name _____ Date of Birth _____ Gender _____
Preferred Pharmacy _____ Pharmacy Telephone Number _____
What is the reason for your visit today? _____
Today's Date _____
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? Circle: Yes / No If yes, what medication? _____
What type of reaction did you have to this medication? _____
Are you currently pregnant or nursing? Circle: Yes / No

Please check all symptoms below you are currently experiencing:

Constitutional:	**Eyes:**	**ENT:**
Fever/Chills	Eye pain	Earache
Feeling poorly	Red eye/discharge	Sore throat
Feeling tired	Vision changes	Nasal congestion/discharge
Recent weight gain/loss	Dry eyes	Nosebleeds
Night sweats	Itchy eyes	Hearing loss
Cardiovascular:	**Respiratory:**	**Gastrointestinal:**
Chest pain	Shortness of breath	Nausea or vomiting
Irregular heartbeat	Cough	Abdominal pain
Leg cramps	Wheezing	Diarrhea
Pain with exercise	**Musculoskeletal:**	Heartburn
Genitourinary:	Joint pain	Constipation
Trouble swallowing	Muscle pain	**Integumentary:**
Dark or bloody stool	Joint swelling	Skin rash
Pain with urination	Joint stiffness	Itching
Frequency/urgency urination	Limb pain/swelling	Skin lesions
Nighttime urination	Muscle cramps/weakness	Change in mole(s)
Incontinence	**Blood/lymph:**	Breast pain/lump
Blood in urine	Easy bruising	Wound/unusual growth on skin
Genital lesion	Swollen glands	**Endocrine:**
Difficulty with menstrual period	**Psychiatric:**	Excessive thirst/urination
Erectile dysfunction	Anxiety	Drooping of eyelid
Neurological:	Depression	Hot or cold tolerance
Headache	Suicidal or homicidal thoughts	Hair loss

Dizziness	Personality changes/irritability	Generalized weakness
Mental changes	Sleep disturbances	
Fainting		
Limb weakness		
Difficulty walking		
Numbness		
Tremor		
Radiating pain		

Personal Medical History (please check all that apply):

ADHD/ADD	Addiction	Allergies, seasonal	Anemia
Anxiety	Arrhythmia	Arthritis	Asthma
Bipolar	Bladder Incontinence	Bleeding	Cancer-please list
Headaches	Crohn's Disease	COPD/Emphysema	Dementia
Diabetes Type 1 or 2	Diverticulitis	DVT (blood clot)	GERD (Acid Reflux)
Glaucoma	Heart Disease	Heart Attack	Hiatal Hernia
High Blood Pressure	Kidney Stones	Kidney Disease	High Cholesterol
HIV/AIDS	Hepatitis	Irritable Bowel	Lupus
Liver Disease	Macular Degeneration	Neuropathy	Osteopenia/Osteoporosis
Parkinson's Disease	Peripheral Vascular	Peptic Ulcer	Psoriasis
Pulmonary Embolism	Rheumatoid Arthritis	Seizure Disorder	Sleep Apnea
Stroke	Thyroid Disease	Ulcerative Colitis	Covid 19
Other:			

Dexa (Bone Density scan)	Yes _____	No _____	Date_____	Normal/Abnormal
Colonoscopy	Yes _____	No _____	Date_____	Normal/Abnormal
PAP	Yes _____	No _____	Date_____	Normal/Abnormal
Mammogram	Yes _____	No _____	Date_____	Normal/Abnormal

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

_____

_____

Women's Health History:

Total number of pregnancies _____ Number of births _____

Date (month/day if known) of last menstrual period if you are still menstruating _____

Age at beginning of periods (menstruation) _____ Age at end of periods (menopause) _____

Social History:

Occupation _____ Employment Status _____

Employer _____

Marital Status _____ Spouse/Partner Name _____

Number of children _____ Ages of children _____ Number of grandchildren _____

Who lives at home with you? _____

Family History: Please indicate which relative has had the following disease(s). If the relative is deceased, indicate cause and year in the comments section. If you are adopted and do not know your genetic history, check here _____.

Disease	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Maternal GM*	*Maternal GF*	*Paternal GM*	*Paternal GF*	*Comments*
No significant history known									
Alcoholism/Drug Abuse									
Alzheimer's									
Asthma									
Autoimmune Disease									
Bleeding or clotting disorder									
Cancer: Breast									
Cancer: Colon									
Cancer: Other Type									
Cancer: Ovarian									
Cancer: Prostate									
Colon Polyp									
Coronary Artery Disease									
Depression/Suicide/Anxiety									
Diabetes									
Emphysema/COPD									
Genetic Disorder (please explain)									
Glaucoma									
Heart Disease									
Hepatitis B or C									
High Blood Pressure/Hypertension									
High Cholesterol									
Hip Fracture									
Hypothyroidism/Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Migraine Headaches									
Osteoporosis									
Other									
Other									
Other									

<u>Other Health Issues:</u>

Tobacco Use

Never _____ No _____ Yes _____

Former smoker I quit smoking on _____ and smoked _____ packs per day.

Current smoker I have smoked _____ years and smoked _____ packs per day.

Other tobacco Pipe _____ Cigar _____ Snuff _____ Chew _____ Vape _____ Other

Alcohol Use

Never _____ No _____ Yes _____

I drink _____ (#) of drinks per week Beer _____ Wine _____ Liquor _____

Drug Use

Do you use marijuana or recreational drugs? No _____ Yes _____

If yes, which drugs? _____

Have you ever used needles to inject drugs? No _____ Yes _____

If yes, which drugs? _____

Exercise/Diet

Do you exercise regularly? Never _____ No _____ Yes _____

What kind of exercise? _____

How long and how often? _____

How would you rate your diet? Good _____ Fair _____ Poor _____

Sexual Activity

Are you sexually involved? No _____ Yes _____

Birth control method(s) _____

Patient Signature _____ **Date** _____