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 where abouts 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)	❑	❑	❑		
Circle any you have taken in the past.					
Ansoid ☐ (flurbiprofin)	Arthrotec ☐ (diciofenac+misoprostill)	Aspirin (including coated aspirin) ☐	Celebrex ☐ (celecoxib)	Clinorill ☐ (sullindac)	Daypro ☐ (oxoprozin)
Disalcid ☐ (saisalate)	Dolobid ☐ (difiunisal)	Feidene ☐ (piroxicom)	Indocin ☐ (indomethacin)	Lodine ☐ (atodolac)	Meciomen ☐ (meciofenamate)
Motrin/Rufen ☐ (ibuprofen)	Naifan ☐ (fenoprofen)	Noprosyn ☐ (noproxen)	Oruvail ☐ (ketoprofen)	Tolectin ☐ (tolmettin)	Trillsate ☐ (choline magnesium trisolicytc)
Vioxx ☐ (rofecoxib)	Voitaren ☐ (cliciofenac)				

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 ☐.

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

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