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 <u>with</u> or <u>without</u> 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 _____			_____	or	_____	Severe Allergies	❑ No	❑ Yes	_____	or	_____
Please Name						Other _____			_____	or	_____
						Please Name					

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: _____