RGi History Form

NAME ____

DATE OF BIRTH ____________________TODAY'S DATE____

WHAT IS THE MAJOR REASON FOR TODAY'S VISIT?

____

____

____

PERSONAL PAST HISTORY:

CIRCLE IF YOU HAVE HAD:

HEENT
- HAY FEVER
- SINUSITIS
- GLAUCOMA
- NOSE BLEEDS

CP
- BRONCHITIS
- PNEUMONIA
- ASTHMA
- EMPHYSEMA
- RHEUMATIC FEVER
- HIGH BLOOD PRESSURE
- HEART DISEASE
- HEART MURMUR

GI
- ULCER/REFLUX
- INFLAMM. BOWEL DISEASE
- HEPATITIS
- CIRRHOSIS OF LIVER
- COLITIS / CROHN'S
- IRRITABLE BOWEL SYNDROME
- HEMORRHOIDS
- COLON POLYPS

GU
- BLADDER INFECTIONS
- KIDNEY DISEASE

ENDO
- DIABETES
- CORTISONE TREATMENT
- THYROID DISEASE

HEMO-ONC
- SCARLET FEVER
- INFECTIOUS MONO
- EXPOSURE TO TB
- CANCER ______________________
- ANEMIA
- BLEEDING TENDENCY
- SEXUALLY TRANSMITTED DISEASE

MUSC
- ARTHRITIS
- BACK TROUBLE

NEURO
- STROKE OR MINI STROKE
- SEIZURES

PSYCH
- DEPRESSION

SKIN
- HIVES

OTHER
- RADIATION THERAPY
- MAJOR INJURY

OPERATIONS:
- JOINT SURG/REPLACEMENT
- APPENDIX
- GALLBLADDER
- STOMACH
- BREAST
- UTERUS AND/OR OVARY
- PROSTATE
- HERNIA
- THYROID
- COLON SURGERY
- HEART
- OTHER

____

ALLERGIES

(ARE YOU ALLERGIC TO):

- PENICILLIN
- SULFA
- OTHER DRUGS
- LIST: _________________________
- ________________________________
- ________________________________
- FOODS
- COSMETICS
- OTHER

IMMUNIZATIONS
- HEPATITIS A
- HEPATITIS B
- TESTED FOR HIV
- HAVE YOU EVER SNORTED OR INJECTED ILLICIT DRUGS

FAMILY HISTORY – HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING: CIRCLE "YES" OR "NO" – IF SO, WHAT RELATIONSHIP:

ANEMIA	YES	NO	______________________
BLEEDING TENDENCY	YES	NO	______________________
HEART DISEASE	YES	NO	______________________
CHRONIC LUNG DISEASE	YES	NO	______________________
TUBERCULOSIS	YES	NO	______________________
ASTHMA	YES	NO	______________________
MIGRAINE HEADACHES	YES	NO	______________________
DIABETES	YES	NO	______________________
OBESITY	YES	NO	______________________
PEPTIC ULCER	YES	NO	______________________
CHRONIC DIARRHEA	YES	NO	______________________
CANCER	YES	NO	______________________
	TYPE:		______________________
	WHO?		______________________
COLON OR GI CANCER	YES	NO	______________________
HEMOCHROMATOSIS	YES	NO	______________________
LIVER DISEASE	YES	NO	______________________
CROHN'S DISEASE	YES	NO	______________________
ULCERATIVE COLITIS	YES	NO	______________________

☐ Please check the box if you would like a chaperone during the physical exam.

MEDICATIONS TAKEN REGULARLY	REASON	LAST DOSE

All Patients – You will be asked to complete this form at each office visit.
Please mark Yes to each item for any symptoms you have experienced in the last month.
If you are not experiencing the symptom, please leave it blank.

Patient Name ______________________ Patient DOB ______________
Date of Service ______________

CONSTITUTIONAL	
Yes	
	Fever
	Chills
	Weight Loss
	Malaise/Fatigue
	Diaphoresis(Sweating)
	Weakness
SKIN	
Yes	
	Rash
	Itching
HENT	
Yes	
	Hearing Loss
	Tinnitus (Ear Ringing)
	Ear Pain
	Ear Discharge
	Nosebleeds
	Congestion
	Stridor (Noisy Breathing)
	Sore Throat

EYES	
Yes	
	Blurred Vision
	Double Vision
	Photophobia (Light Intolerance)
	Eye Pain
	Eye Discharge
	Eye Redness
CARDIOVASCULAR	
Yes	
	Chest Pain
	Palpitations
	Orthopnea (Breathing Discomfort)
	Claudication (Leg pain from exertion)
	Leg Swelling
	PND (Shortness of breath at night)
RESPIRATORY	
Yes	
	Cough
	Hemoptysis (Coughing up blood)
	Sputum production
	Shortness of breath
	Wheezing

GASTROINTESTINAL	
Yes	
	Heartburn
	Nausea
	Vomiting
	Abdominal pain
	Diarrhea
	Constipation
	Blood in stool
	Melena (black stool)
GENITOURINARY	
Yes	
	Dysuria (painful/difficulty urinating)
	Urgency
	Frequency
	Hematuria (blood in urine)
	Flank Pain
MUSCULOSKELETAL	
Yes	
	Myalgias (muscle pain)
	Neck pain
	Back pain
	Joint pain
	Falls

ENDO/HEME/ALLERGY	
Yes	
	Easy Bruise/bleed
	Environmental Allergies
	Polydipsia (Excess thirst)
NEUROLOGICAL	
Yes	
	Dizziness
	Headaches
	Tingling
	Tremor
	Sensory Change
	Speech Change
	Focal Weakness
	Seizures
	LOC (Loss of consciousness)
PSYCHIATRIC	
Yes	
	Depression
	Suicidal Idea
	Substance abuse
	Hallucinations
	Nervous/Anxious
	Insomnia (Diff. Sleeping)
	Memory Loss