RED RIVER INTERNAL MEDICINE

NAME: _____

(LAST) (FIRST) (MIDDLE)

ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP)

PHONE: _____

(HOME) (WORK) (CELL)

DATE OF BIRTH: _____ MARITAL STATUS: SINGLE MARRIED DIVORCED SEPERATED WIDOWED

EMERGENCY CONTACT: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR OFFICE: _____

CURRENT MEDICATIONS WITH DOSAGES AND FREQUENCY:

(LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS, EVEN IF TAKEN INTERMITTENTLY)

_____

_____

_____

_____

MEDICATION ALLERGIES: (PLEASE INCLUDE THE TYPE OF REACTION YOU HAVE TO EACH MEDICATION)

_____

DO YOU SMOKE? YES NO

QUIT: _____ QUANTITY: _____ HOW LONG: _____

DO YOU DRINK ALCOHOL? YES NO TYPE: _____ FREQUENCY: _____

DO YOU USE RECREATIONAL DRUGS? YES NO TYPE: _____ FREQUENCY: _____

DO YOU HAVE A HISTORY OF IV DRUG USE? YES NO

WHAT IS YOUR OCCUPATION? _____

IF RETIRED, WHAT WERE YOUR PAST OCCUPATIONS? _____

FAMILY MEDICAL HISTORY:

FATHER:	MOTHER:
SIBLINGS:	OTHER:
GRANDPARENTS:	

_____

PHYSICIAN SIGNATURE **DATE**

RED RIVER INTERNAL MEDICINE

DO YOU REQUIRE ASSISTANCE WITH TRANSPORTATION? YES NO (IF YES, PLEASE PROVIDE DETAILS)

_____

_____

DO YOU LIVE ALONE? YES NO (IF NO, PLEASE PROVIDE DETAILS)

_____

_____

IMMUNIZATIONS/CHILDHOOD ILLNESSES (PROVIDE DATES IF KNOWN)

CHICKEN POX	COVID	HEPATITIS B	INFLUENZA
MMR	PNEUMONIA	POLIO	TDAP

LIST PREVIOUS SURGERIES WITH DATES:

_____

_____

_____

_____

LIST PREVIOUS OR CURRENT MEDICAL PROBLEMS OR HOSPITALIZATIONS:

_____

_____

_____

_____

DO YOU HAVE A COPAY FOR PRESCRIPTION MEDICATIONS? YES NO

DO YOU PREFER 30- OR 90-DAY PRESCRIPTIONS FOR CONTINUED MEDICATIONS? _____

LIST ANY OTHER PHYSICIANS WHO ARE CURRENTLY TREATING YOU OR PRESCRIBING MEDICATIONS:

_____

_____

PHYSICIAN SIGNATURE **DATE**

RED RIVER INTERNAL MEDICINE

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

CIRCLE ALL THAT APPLY AND/OR FILL IN THE BLANKS. WRITE IN ANY OTHER COMPLAINTS OR COMMENTS IN THE SPACE PROVIDED ON THE NEXT PAGE. ALL ITEMS LEFT UNMARKED ARE CONSIDERED TO BE NEGATIVE.

GENERAL:	Fatigue / Fever / Chills / Weight Loss / Weight Gain / Night Sweats / Difficulty with Sleep
EAR NOSE THROAT:	Headache / Migraines / Vision Loss / Ringing in Ears / Earaches / Sore Throat / Glaucoma / Dizziness / Ear Infections / Vertigo / Sinus / Allergies / Nosebleeds / Cold Sores Last Eye Doctor Visit: _____ Last Dental Visit: _____
NECK:	Swollen Lymph Nodes / Goiter / Muscle Spasm / Carotid Artery Stenosis or Blockage / Stiffness / Pain / Thyroid Problems
HEART:	Chest Pain / Palpitations / Leg or Feet Swelling / Heart Attack / Murmur / Rheumatic Fever / Requires More Than Two Pillows / Awake Short of Breath During Night / Mitral Valve Prolapse (MVP) / Abnormal Stress Test or Echo / Elevated Cholesterol
LUNGS:	Asthma / Bronchitis / Cough / TB Exposure / Shortness of Breath / Pain with Breathing / Wheezing / COPD / Pneumonia / Covid-19
GASTROINTESTINAL:	Ulcers / Acid Reflux or Heartburn / Nausea / Vomiting / Diarrhea / Constipation / Blood in Stool / Black Tarry Stool / Abdominal Pain / Irritable Bowel / Gallstones / Hemorrhoids / White Stool / Hepatitis / Jaundice / Difficulty or Pain Swallowing Solids or Liquids / Recent Changes in Bowel Movements or Bowel Habits
GENITOURINARY:	Kidney Stones / Painful Urination / Blood in Urine / Difficulty Starting or Stopping Urination / Urgency / Frequent Urination at Night / Venereal Disease / Painful or Swollen Testicles / Leaking Urine / Difficulty with Sexual Function
GYNECOLOGY:	Menstrual Cramps / Heavy Bleeding / PMS / Irregularity / Frequency / ____ Days / Headaches / Menopausal / Age at Menopause: ____ / Hot Flashes / Mood Swings / Vaginal Dryness / Breast Mass / Loss of Libido / Pain During Intercourse / Abnormal Pap Smear / Abnormal Mammogram / Miscarriage Last Mammogram: _____ Last Pap Smear: _____ Last Bone Density Scan: _____ Number of Pregnancies: _____ Number of Live Births: _____ Diabetes During Pregnancy:_____ Have you taken hormones: _____ Any problems with hormones: _____

_____

PHYSICIAN SIGNATURE **DATE**

RED RIVER INTERNAL MEDICINE

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS (CONTINUED)

MUSCULOSKELETAL:	Arthritis / Joint Pain / Back Pain / Muscle Cramps or Spasms / Muscle Aches / Fractures or Trauma / Scoliosis / Back Injury / Tendonitis / Fibromyalgia / Muscle Weakness / Osteoporosis
NEUROLOGICAL:	Seizures / Numbness / Tingling / Stroke / TIA ("Mini Stroke") / Weakness / Tremor
SKIN:	Rashes / Easy Bruising / Itching / Warts / Skin Cancer / Moles / Dry Skin / Hair Loss / Brittle Nails / Hives / Nail Fungus
HEME:	Anemia / History of Blood Transfusion / Sickle Cell / Sickle Trait
LYMPHATICS:	Enlarged Lymph Nodes in: Neck / Groin / Armpit / Other: _____
PSYCHIATRIC:	Depression / Anxiety / Eating Disorder / Panic Disorder / Prior Treatment for Other Conditions: _____
ENDOCRINE:	Heat Intolerance / Cold Intolerance / Excessive Thirst / Previously Taken Steroids / Other Gland Problems: _____

ANY OTHER PROBLEMS OR CONCERNS THAT YOU MAY HAVE CAN BE LISTED AND DESCRIBED BELOW:

_____

_____

_____

_____

_____

_____

PHYSICIAN SIGNATURE **DATE**