Richards And Richardson PC

Patient Name: (First Name Middle Initial Last Name)	Sex:	Date of Birth:
Mailing Address: (Street City, State Zip)	Home Phone:	Social Security #:
Name of Employer:	Work Phone:	Occupation:

Responsible Party

Name of Responsible Party:	Date of Birth:	Social Security #:	Phone: (
Responsible Party Address:	Responsible Party Employer:		Work Phone:
Occupation:	Relationship to patient:		Sex: F

Emergency Contact

Emergency Contact:	Relationship to patient:	Phone:

Primary Insurance Coverage

Primary Insurance Company:	Address:		
Subscriber Name:	Subscriber DOB:	Policy #:	Group #:
Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐		

Secondary Insurance Coverage

Secondary Insurance Company:	Address:		
Subscriber Name:	Subscriber DOB:	Policy #:	Group #:
Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐		

Authorization

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Richards and Richardson PC when they accept assignment.
Authorization To Release Medical Information. I hereby authorize Richards and Richardson PC to release any information necessary for my course of treatment.
Authorization To Contact: I grant permission to Richards and Richardson PC to contact me at home or work to discuss matters related to this patient. Also, I authorize the staff at Richards and Richardson PC to leave a detailed message with results at the following phone number:_____

_____ _____
Patient/Responsible Party Signature Date

I _____ authorize Richards and Richardson PC to discuss any and all health related issues
(patient name)
With _____. Relationship to patient:_____ Phone number:_____
Pharmacy Name, Address & Phone number:_____

Richards & Richardson P.C.

PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Name:_____ DOB:_____ Date:_____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

# Acid Reflux (heartburn)	# Alcoholism	# Allergies (environmental)
# Anxiety	# Asthma	# Atrial Fibrillation
# Cancer (list below)	# Cholesterol Problem	# Coagulation (bleeding) Problem
# Chronic Low Back Pain	# Depression	# Diabetes
# Erectile Dysfunction	# Gout	# High Blood Pressure
# Heart Disease (explain below)	# Migraines	# Osteopenia / Osteoporosis
# Prostate Problems	# Thyroid Problems	

Other Chronic or Recurring Medical Problems (Please list below)

_____

_____

_____

_____

Have you had any of the following testing done? Please answer yes or no to all that pertain to you.

Colonoscopy :_____ date performed: __/_____/_____

Mammogram:_____ date performed: ___/_____/_____

Annual Eye Exam:_____ date performed ___/_____/_____

Annual Gynecological Exam:_____ date performed ___/_____/_____

Annual Dental Exam:_____ date performed ___/_____/___

Diabetic Eye Exam:_____ date performed __/_____/_____

Diabetic Foot Exam:_____ date performed __/_____/____

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: # Y # N_____Pneumonia: # Y # N_____Covid-19 vaccine: # Y # N_____Flu Vaccine: # Y # N_____

Shingles: # Y # N_____

Patient Name:_____ Date: _____

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history #

MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES	MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

Name:_____

Date:_____/_____/_____

SOCIAL HISTORY:

Tobacco Use

Please check one

I have never smoked

I have smoked, but rarely

When was the last time?_____

I have quit smoking. Quit Date:_____

How many packs/day?_____How many yrs?_____

I currently smoke_____pack(s)/day.

How many yrs._____

Alcohol Use

Do you drink alcohol? # Y # N

never # occasionally # regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? # Y # N

Sexual History

Are you sexually active? # Y # N # not currently

Current control method:_____

Have you ever had any sexually transmitted diseases (STD's)? # Y # N Date:_____Which STD?_____

Are you interested in being screened for sexually transmitted diseases? # Y # N

Exercise

Do you exercise? # Y # N How often? # Daily # 4 – 6x a week # 1 – 3x a week # less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? # Y # N

Socioeconomics

Marital Status: # single # married # separated # divorced # widow

Occupation:_____

Education completed: # grade school # high school # college # graduate school

Number of children:_____Who lives at home with you?_____

Frequent foreign travel? # Y # N Where?_____

PRIOR SURGERIES AND HOSPITALIZATIONS: # Yes # No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Name:_____ Date: _____/_____/_____

REVIEW OF SYSTEMS (please circle any *CURRENT* problems you have on the list below)

General

- Fatigue / Weakness
- Restless Sleep
- Daytime Drowsiness
- Unhappiness
- Depression / Sadness
- Feeling "Blue" or Hopeless for More than 2 wks
- Lack of Motivation
- Excessive Irritability
- Feelings of Worthlessness
- Nervous / Anxiety
- Unexplained Fever (> 100.0)
- Frequent Night Sweats
- Unexplained Weight Loss
- Unexplained Weight Gain
- Excessive Thirst

Skin

- Changes in Moles / Unusual Moles
- Concerns re: skin spots / rashes / growths
- Bruise Easily
- Itching
- Excessive Hair Growth
- Hair Loss

Ears / Nose / Throat

- Allergy Symptoms
- Hearing Loss
- Ringing in the Ears
- Dizzy Spells / Dizziness
- Nose Bleeds
- Sinus Problems
- Hoarseness – Frequent

Eyes

- Eye Pain
- Double Vision / Change in Vision
- Itchy / Watery Eyes

Lungs

- Cough / Wheeze
- Snoring / Gasping at Night During Sleep
- Difficulty Breathing
- Positive TB Skin Test

Heart

- Chest Pain / Pressure
- Recent Change in Exercise Tolerance
- Heart Murmur
- Palpitations / Irregular Pulse
- Fainting Spells
- Swollen Ankles
- Leg Pain with Walking / Exercise

Gastrointestinal

- Abdominal Pain
- Heartburn / Indigestion
- Change in Bowel Habits – Recent
- Difficulty Swallowing
- Persistent Nausea / Vomiting
- Diarrhea / Constipation
- Bloody or Black Tarry Stools
- Frequent Laxative Use? How Often?

Musculoskeletal

- Muscle / Joint Pain
- Recurrent or Chronic Back Pain
- Joint Swelling
- Gout

Genitourinary

- Frequent Urine Infections
- Painful Urination
- Frequent Urination
- Urinary Leakage / Incontinence
- Blood in Urine
- Overnight Urination > 2 x
- Sexual Function Problems

Male

- Decrease in Force of Urination
- Erection Problems
- Testicle Lumps / Swelling

Female

- Vaginal Discharge / Itching
- History of Abnormal Pap Smear
- Pain / Bleeding During Sex
- Significant Pain / Cramps with Menses
- Hot Flashes / Night Sweats

Menstrual History

- Age of onset_____reg. / irreg. / menopause
- Flow: heavy / moderate / light
- Length of cycle_____Days of flow_____
- # of pregnancies_____# ofbirths _____
- # of miscarriages / abortions _____

Breast

- Pain / Lumps / Discharge

Neurological

- Frequent Headaches
- Numbness / Tingling
- Memory Loss
- Tremor / Shaking

Explanation:_____

Medication Log

Name _____

Date _____

Date Of Birth _____

Allergies _____

Allergies _____

Allergies _____

Doctor _____

_____

Pharmacy _____

Pharmacy Phone # _____

Medication	Dosage	Frequency

Acknowledgement of receipt of Notice of Privacy Practices

Richards & Richardson, P.C.

Reserves the right to modify the Privacy Practices outlined in the Notice Signature

I have received a copy of the notice of Privacy Practices for Richards & Richardson, P.C.

_____

Name of Patient (print)

_____

Signature of Patient

_____

Date

_____

Signature of patient representation

(Required if patient is a minor or an adult who is unable to sign the form)

_____

Relationship of patient representative to patient

Dear Patients,

Richards and Richardson P.C. now have our own patient portal through, Follow My Health. This portal is a secure site where you are able to have access to your chart. By giving Richards and Richardson P.C. your Email address we can send you a link to **Follow My Health.**

On this site you will be able to;

- **Request refills on medications**
- **Send messages to the office**
- **Email reminders of your upcoming appointment**
- **View your labs**
- **Change demographics**

Please fill out the information below as to whether or not you are interested in the Patient Portal.

Thank you!

Date:_____

Patient Name (printed):_____

Signature:_____

Email address:_____

_____ **yes I am interested. Please send me a link to Follow My health.**

_____ **No, I am not interested. Please do not send me a link to Follow My health.**