RAVRY MEDICAL GROUP

Internal Medicine and Gastroenterology

NAME:______________________ DATE OF BIRTH:____________ AGE ______ MARITAL STATUS S M W D

OCCUPATION ______________________ EDUCATION ______________________

Have you lived or traveled outside the U.S. or Canada? Where and when:

____

____

____

Have you ever been refused for life insurance or rejected for military service? Yes No

If yes, why? ______________________

	Living		Age/age at death	Present health/cause of death
Mother	Yes	No		
Father	Yes	No		
Spouse	Yes	No		
	# living	# dead		Health/cause of death/age at death
Brothers				
Sisters				
Children				

Circle Illnesses or conditions you have had

High Blood Pressure, Mononucleosis, Heart trouble, Lung Disease, Thyroid Trouble

Venereal Disease, Vein Trouble, Kidney Disease, Arthriitis, Diabetes

Bleeding Tendencies, Nervous Disorder, Tuberculosis, Jaundice, Cancer

Digestive or Intestinal Disorders, Other______________________

Circle Illnesses which have occurred in any of your blood relatives

Bleeding Tendency, Kidney Disease, Tuberculosis, Diabetes, Cancer, Heart Disease, Allergy, Stroke

High Blood Pressure, Nervous Illness, Other______________________

List any hospitalizations you have had for:

Operations: ______________________

____

Illness: ______________________

____

Injury: ______________________

____

Other: ______________________

____

Check the diseases against which you have been immunized: Give dates

☐ Flu ________ ☐ Pneumonia ________ ☐ Measles ________ ☐ Polio ________ ☐ Hepatitis B ________ ☐ Tetanus ________

Are you allergic/intolerant to any drugs, foods or other products? Please list:

____

____

List any chemical agents, fumes or dust to which you are exposed at work:

____

Medications: List any prescription medications you now use or recently have used:

____

____

List any non-prescription products you now use or have recently used:

____

____

Have you ever taken Cortisone-type drugs? ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No Hormones? ☐ Yes ☐ No

Social History

Do you smoke Now ______ In the past ______ # of years ______ Never ______

Cigarettes ______ Cigar/Pipes ______ # per day ______

Do you drink Liquor ______ Beer ______ Wine ______

Coffee ______ Number of cups per day

Do you ever use Recreational Drugs? ☐ Yes ☐ No

Do you routinely use Seat Belts? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Is your sex life satisfactory? ☐ Yes ☐ No

Are you gay/bisexual? ☐ Yes ☐ No

PP0245 (RMG_A) NEW PATIENT PACK

REVIEW OF SYSTEMS

GENERAL Have you RECENTLY had

PHYSICIAN COMMENTS

	Yes	No
Fever, night sweats, chills		
Unusual weight changes		

Highest Weight ___________ Lowest Weight ____________

SKIN Have you noticed

	Yes	No
Any changes in skin color		
Sores or wounds that do not heal		
Skin rashes or itching		
Growth/changes in moles or warts		

EYES Have you had

	Yes	No
Trouble with your vision		
Cataracts		
Glaucoma		
Itchy/watery eyes		
Date of last eye exam		

ENT Have you had

	Yes	No
Difficulty hearing		
Ear infections or discharge		
Earaches or ringing in ears		
Dizziness		
Nosebleeds		
Sinus Trouble		
Persistent hoarseness		
Bleeding gums		
Sore tongue or mouth		
Hay fever		
Chronic nasal drainage		
Dental problems		

RESPIRATORY Have you...

	Yes	No
Had a constant or bothersome cough		
Coughed up phlegm or sputum		
Ever cough up blood		
Had difficulty breathing		
Had pneumonia, bronchitis or asthma		
Ever been in contact with TB		
or had a positive skin test for TB		

CARDIOVASCULAR Have you had...

	Yes	No
Chest pain, tightness, discomfort or pressure		
Light headedness or ever passed out		
Swelling of feet or ankles		
Pain in calf when walking		
Fast or irregular heart beat		
High blood pressure		
An abnormal electrocardiogram		
A heart mumur		
A stress test or treadmill test		

ENDOCRINE SYSTEM Have you ever...

	Yes	No
Had heat or cold intolerance		
Had thyroid problems		
Been treated for Diabetes		
Been placed in hormone therapy for any condition		
Had lumps in your breasts or		
Enlargement of your breasts		
Had any discharge from your nipples		

GASTROINTESTINAL Do you have...	Yes	No
A poor appetite		
Trouble swallowing solids or liquids		
Stomach trouble, indigestion or heartburn		
Constipation		
Diarrhea or loose stools		
Any recent change in bowel movements		
Rectal bleeding or tarry/black movements		
Gallbladder problems or gallstones		
Liver disease		
Pancreatitis		

Have you ever...

Vomited blood		
Had an ulcer		
Taken laxatives regularly		
Been told you had yellow jaundice		
Had any special food that causes stomach upset pains, nausea, etc.		

GENITOURINARY Have you had...

Burning or pain when urinating		
To awake at night to urinate		
Trouble urinating or straining		
To urinate frequently		
Dribbling urine		
Prostate trouble		
Trouble losing urine when coughing or sneezing		
Blood in your urine		
Kidney stones		
Bladder or kidney infections		

MUSCULOSKELETAL Have you had...

Neck or back pain		
Pain in your legs or feet		
Joint pain or stiffness		
Trouble walking or using your hip or knee joints		
Any stiffness in your joints in the mornings		
Any change in the strength of your muscles		
Treatment for arthritis		

CENTRAL NERVOUS SYSTEM Have you ever...

Had frequent or severe headaches		
Had trouble remembering recent events		
Had convulsions or fits		
Had numbness or tingling head, arms or legs		
Lost the ability to speak for a few seconds		
Considered yourself a nervous person		
Had spells of dizziness, faintness or light headedness		
Had excessive snoring or fatigue in the mornings		
Had crying spells for no reason		
Heard voices or see people when no one is around		
Recently fainted, blacked out or lost consciousness		
Ever had the urge to commit suicide		
Ever been treated by a psychiatrist		
Ever been treated for tension headaches or migraine headaches		

PHYSICIANS COMMENTS

HEMATOLOGIC Have you...	Yes	No
Received iron tablets, B12 injections or other treatments for anemia		
Been susceptible to infections in the past		
Had excessive bleeding or bruising		
Ever been told that your blood count was low		
Ever received a blood transfusion		
________________ Date of Transfusion		
Ever been rejected as a blood donor		
Is there a family history of sickle cell or other anemia		
Has a relative or associate of yours been treated for AIDS or other immune disorder		

PHYSICIANS COMMENTS

WOMEN ONLY Have you had...	Yes	No
An intrauterine device (IUD)		
Clots with your periods		
The menopause or change		
Hot flashes		
Excessive body or facial hair		
Do you use more than 10 pads or have to use a super size pad or tampon		
Do you become bloated or gain weight before your periods		
What kind of birth control measures have you used		

MENSTRUAL HISTORY

Last period (date)		
Periods regular irregular		
Number of pregnancies		
Number of miscarriages		

____

PATIENT SIGNATURE

____

DATE