

Pharmacy Information			
Preferred Pharmacy		Secondary Pharmacy	
Name		Name	
Address		Address	
Phone		Phone	
Fax		Fax	
Advanced Directives			
<input type="checkbox"/> None <input type="checkbox"/> Do Not Resuscitate <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Living Will <input type="checkbox"/> HC Proxy			
Date Reviewed:			
Medications – List all medications you take, prescription and non-prescription, and the dosage			
<input type="checkbox"/> I do not take any medications			
Medication Name		Dosage	
Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)			
<input type="checkbox"/> No Known Allergies			
Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	Year	Condition	Year
<input type="checkbox"/> None		<input type="checkbox"/> Gallbladder Disease	
<input type="checkbox"/> Allergies		<input type="checkbox"/> GERD (Reflux)	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hepatitis C	
<input type="checkbox"/> Angina		<input type="checkbox"/> Hyperlipidemia	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Cancer – Type		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cerebrovascular Accident		<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> COPD (Emphysema)		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Crohn’s Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Depression		<input type="checkbox"/> Other	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other	



Surgical History – Check if you have received the following procedures, and year performed.							
Surgical Procedure	Year	Surgical Procedures			Year		
<input type="checkbox"/> None		Male Only					
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Prostate Biopsy					
<input type="checkbox"/> Angioplasty w/Stent		<input type="checkbox"/> TURP					
<input type="checkbox"/> Appendectomy		(Trans-urethral resection of Prostate)					
<input type="checkbox"/> Arthroscopy Knee		<input type="checkbox"/> Vasectomy					
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Other					
<input type="checkbox"/> CABG (heart bypass)		<input type="checkbox"/> Other					
<input type="checkbox"/> Carpal Tunnel Release							
<input type="checkbox"/> Cataract Extraction		Female Only					
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Augmentation Mammoplasty					
<input type="checkbox"/> Colectomy		<input type="checkbox"/> Bilateral Tubal Ligation					
<input type="checkbox"/> Colostomy		<input type="checkbox"/> Breast Biopsy					
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Cesarean Section					
<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> D and C					
<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> Hysterectomy					
<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> Mastectomy					
<input type="checkbox"/> LASIK		<input type="checkbox"/> Myomectomy					
<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Reduction Mammoplasty					
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> TAH/BSO					
<input type="checkbox"/> Small Bowel Resection		<input type="checkbox"/> Vaginal Hysterectomy					
<input type="checkbox"/> Thyroidectomy		<input type="checkbox"/> Other					
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Other					
Health Maintenance – Check if you have received the following, and date of most recent exam.							
Exam	Date	Exam	Date				
<input type="checkbox"/> None		<input type="checkbox"/> GYN Exam					
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> Influenza Vaccine					
<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Lipid Panel					
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Mammogram					
<input type="checkbox"/> DEXA Scan		<input type="checkbox"/> PAP Test					
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Physical Exam					
<input type="checkbox"/> EKG		<input type="checkbox"/> Pneumococcal Vaccine					
<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Pulmonary Function Test					
<input type="checkbox"/> FOBT (stool card for hidden blood)		<input type="checkbox"/> Sigmoidoscopy					
<input type="checkbox"/> Foot Exam		<input type="checkbox"/> Tetanus Vaccine					
Family History – Check if any family member(s) has had any of the following conditions.							
<input type="checkbox"/> Adopted							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAD (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer – Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia (High Cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social History for Adult Patient							
Occupation				Employer			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many?		Female(s)		Male(s)	
Tobacco Use		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less		<input type="checkbox"/> Chewing <input type="checkbox"/> Pipe		<input type="checkbox"/> Cigar <input type="checkbox"/> Cigarette	
<input type="checkbox"/> No		<input type="checkbox"/> Former/Year quit:		<input type="checkbox"/> Smokeless Brand:			
Alcohol Use		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less		<input type="checkbox"/> Beer <input type="checkbox"/> Wine		<input type="checkbox"/> Liquor <input type="checkbox"/> Other:	
<input type="checkbox"/> No		<input type="checkbox"/> Former/Year quit:					
Exercise Activity		<input type="checkbox"/> Moderate <input type="checkbox"/> Vigorous <input type="checkbox"/> Sedentary		Sleep Pattern:			
		Days/Week:		<input type="checkbox"/> Changes <input type="checkbox"/> No Changes			
Caffeine Use		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less		<input type="checkbox"/> Chocolate <input type="checkbox"/> Coffee		<input type="checkbox"/> Soda <input type="checkbox"/> Tea	
<input type="checkbox"/> No		<input type="checkbox"/> Former/Year quit:		<input type="checkbox"/> Tablets <input type="checkbox"/> Other:			
For Pediatric Patient							
Patient Reside with:		Primary	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Other:	
		Secondary	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other:		
Mother's Occupation				Father's Occupation			
Parents Relationship				Childcare			
<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Mother <input type="checkbox"/> Grandparent			
<input type="checkbox"/> Divorced <input type="checkbox"/> Separated				<input type="checkbox"/> Father <input type="checkbox"/> Nanny			
<input type="checkbox"/> Widowed				<input type="checkbox"/> Sibling <input type="checkbox"/> Daycare			
Tobacco Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No				Patient is current smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Smokers at home: <input type="checkbox"/> Yes <input type="checkbox"/> No							

Patient Information					
First Name		Last Name		MI	Date of Birth
Address		City		State	Zip
Please check Primary phone	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>		
Other Name(s) Used			E-mail Address		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Preferred Language		Driver's License	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner	Preferred Contact <input type="checkbox"/> Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Patient Portal (MyChart)	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline	Race <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		
Primary Care Provider			Referring Provider		
Responsible Party (Guarantor)					<input type="checkbox"/> Same as patient
First Name		Last Name		MI	Date of Birth
Address		City		State	Zip
Please check Primary Phone	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>		
SSN	Relationship to Patient	Preferred Language	Driver's License		
Emergency Contact (for minor child, this section may be used for other parent)					
First Name		Last Name		MI	Date of Birth
Address		City		State	Zip
Please check Primary Phone	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>		
I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the RiverCity Family Medicine, PLLC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize RiverCity Family Medicine, PLLC to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.					
_____ Signature of Patient/Responsible Party			_____ Date		
_____ Name of Patient/Responsible Party (Please Print)			_____ Relationship to Patient		