River Ridge
FAMILY HEALTH

Comprehensive Health History

Patient Name: _____ DOB: _____ Date:_____

- **Gender:** [ ] Male [ ] Female [ ] Other
- **Phone number:**_____
- **Home address:** _____
- **Email address:**_____
- **Preferred pharmacy:**_____
- **Height and weight:**_____

Recent Vitals

- **Blood Pressure:**_____
- **Heart Rate:**_____
- **Oxygen:**_____
- **Temperature:**_____

Current Medications & Supplements

Please include all prescribed medications, over the counter medications, vitamins and supplements you are currently taking.

Include dosage and frequency if known.

1. _____
2. _____
3. _____
4. _____

Allergies

Please list medication, food, or environmental allergies and your reaction if known (e.g., hives, swelling).

- [ ] No Known Drug Allergies (NKDA)
- _____
- _____
- _____

Medical History

Please check all that apply to you, current or in the past and when each started.

[ ] Hypertension [ ] Diabetes [ ] Heart disease [ ] Stroke [ ] Circulatory problems [ ] Lung disease [ ] Asthma/COPD [ ] Tuberculosis [ ] Kidney disease [ ] Liver disease [ ] Hepatitis [ ] HIV/AIDS [ ] Bowel disease [ ] Urinary disease [ ] Anxiety/Depression [ ] Cancer (Type:_____) [ ] Endocrine disease [ ] Thyroid disease [ ] Obesity [ ] High cholesterol [ ] Arthritis [ ] Osteoporosis [ ] Chronic pain [ ] Autoimmune disease [ ] Seizure disorder [ ] Migraines [ ] Gout [ ] Anemia [ ] Bleeding disorder [ ] Reflux disease [ ] Other: _____

Surgical & Hospitalization History

Please list any surgeries or major hospital stays in your lifetime and dates if known.

1. _____
2. _____
3. _____
4. _____
5. _____

Preventative Screenings

Please include any screenings, dates and results to include pap smear, mammogram, colonoscopy, cologuard, fecal occult blood test, lung cancer screening, lab work.

- _____
- _____
- _____

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Family History

Please list any medical conditions that members of your family (parents, siblings, grandparents) have had, who had them and age of onset if known.

- Heart Disease/Stroke:
- Cancer: (Type:_____)
- Diabetes:
- High blood pressure:
- High cholesterol:
- Lung disease:
- Kidney disease:
- Liver disease:
- Bowel disease:
- Urinary disease:
- Endocrine disease:
- Other:

Lifestyle & Social History

- Tobacco Use: [ ] Never [ ] Former [ ] Current (___ packs/day)
- Alcohol: [ ] None [ ] Occasional [ ] Daily (___ drinks/week)
- Drug Use: Yes/No If yes (type): _____
- Occupation: _____
- Place of birth:
- Exercise Level: [ ] Low [ ] Mod [ ] High. Type of exercise:
- Diet:
- Caffeine intake:

Previous Medical Provider

- Name of provider and practice: _____
- When were you last seen?_____
- Do you see any specialists? Yes/No
- If yes, name of provider and practice and when you were last seen: _____

Vaccines Please list any vaccines you have ever had and dates if known.

- _____
- _____
- _____

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General Consent to Treat

Authorization for Care

I, the undersigned, hereby voluntarily consent to medical evaluation, testing, and treatment provided by River Ridge Family Health. I understand that this may include physical exams, diagnostic tests, and minor procedures.

****PLEASE NOTE THAT WE DO NOT PROVIDE CHRONIC PAIN MANAGEMENT****

No Guarantee of Results

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the outcome of any examination or treatment.

Patient Participation

I understand that my active participation and honesty regarding my medical history, symptoms, and lifestyle are essential to receiving safe and effective care.

Mental Health & Sensitive Data

I authorize the provider to document and maintain records regarding my physical and mental health. (Note: Specific HIPAA releases apply for sharing this data with third parties).

Acknowledgement: I have read this form (or had it read to me) and I fully understand its contents. I certify that I am the patient or the patient's legal representative.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____