Raphael Medicine & Therapies PC
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Please fill out this form with the information of the patient. Please bring this form **COMPLETED** to your scheduled appointment. Thank you.

PATIENT INFORMATION: **TODAY'S DATE: ___/___/___**

NAME: _____ Phone (H): _____ (c) _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
OCCUPATION: _____ DATE OF BIRTH: _____ AGE _____
EMAIL: _____ INSURANCE? NO YES PPO OTHER: _____

FAMILY HISTORY- If any blood relative has suffered any of the following- please indicate.

- ☐ Tuberculosis_____
- ☐ Hypertension_____
- ☐ Gout_____
- ☐ Kidney Disease_____
- ☐ Mental Illness_____
- ☐ Epilepsy_____
- ☐ Stroke_____
- ☐ Migraine_____
- ☐ Arthritis_____
- ☐ Diabetes_____
- ☐ Cancer_____
- ☐ Heart Attack _____
- ☐ Glaucoma_____

Briefly describe why you came to the Doctor today:

_____
_____
_____

HOSPITALIZATIONS/ SURGERIES/ INJURIES

_____
_____

IMMUNIZATIONS: _____
ALLERGIES: NONE ☐ PENICILLIN ☐ SULFA ☐ OTHER: _____
MEDICATIONS/ SUPPLEMENTS: _____
BLOOD TYPE: _____

PLEASE CHECK ( ) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES:

- ☐ Double or Blurred Vision
- ☐ Eye Infection-frequent
- ☐ Nose Bleeds -recurrent
- ☐ Sinus Trouble
- ☐ Sore Throat-frequent
- ☐ Hay fever/Allergies
- ☐ Hoarseness-prolonged
- ☐ Decreased Hearing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Irregular Pulse
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain when Walking
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Gall Bladder Trouble
- ☐ Jaundice/Hepatitis
- ☐ Hernia
- ☐ Urine infections-frequent

- [ ] Ringing in Ear
- [ ] Ear infections-frequent
- [ ] Dizzy Spells
- [ ] Failing Vision
- [ ] Pneumonia/Pleurisy
- [ ] Bronchitis/Chronic Cough
- [ ] Asthma/Wheezing
- [ ] Shortness of Breath on exertion
  - [ ] lying flat
- [ ] Weight loss-recent
- [ ] Anemia
- [ ] Bruise easily
- [ ] Cancer
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Convulsions/Seizures
- [ ] Stroke
- [ ] Tremor/Hands Shaking
- [ ] Muscle Weakness
- [ ] Numbness/Tingling Sensations
- [ ] Headaches-frequent
- [ ] Arthritis/Rheumatism
- [ ] Varicose Veins/Phlebitis
- [ ] Loss of Appetite-recent
- [ ] Difficulty Swallowing
- [ ] Indigestion or Heartburn
- [ ] Persistent Nausea/Vomiting
- [ ] Peptic Ulcers
- [ ] Abdominal Pain-chronic
- [ ] Change in Bowel Habits
- [ ] Diarrhea
- [ ] Back Pain-recurrent
- [ ] Bone Fracture/Joint Injury
- [ ] Gout
- [ ] Foot Pain
- [ ] Cold Numb Feet
- [ ] Rashes
- [ ] Hives
- [ ] Psoriasis
- [ ] Eczema
- [ ] Sleep-difficulty
- [ ] Nervousness
- [ ] Depression
- [ ] Memory Loss
- [ ] Painful Urination
- [ ] Blood in Urine
- [ ] Overnight Urination-more than 2
- [ ] Control in Urination
- [ ] Decrease in force of Urination
- [ ] Kidney Stones
- [ ] Venereal Disease
- [ ] Urethral Discharge
- [ ] Chronic fatigue
- [ ] Moodiness-excessive
- [ ] Phobias
- [ ] Mental Illness
- [ ] Chicken Pox
- [ ] Polio
- [ ] Measles/German Measles
- [ ] Rheumatic/Scarlet Fever
- [ ] Mumps
- [ ] Tuberculosis
- [ ] Alcohol (____oz/week)
- [ ] Smoking (____packs/week)
- [ ] Coffee (____cups/day)

Any life-threatening situations? ◯ **or** ◯ **If Yes, please describe** _____

For patients over 50 years of age: When was your last colonoscopy? _____

FEMALE MENSTRUAL HISTORY:

Last period: _____ Age of Onset: _____
Please describe your cycle: ◯ Regular ◯ Irregular ◯ Heavy ◯ Light # of days: _____

Length of Cycle: _____ Pain/Cramps-use Medications: _____ Pain/Bleeding After Intercourse: _____

Pregnant: YES or NO If YES, Name of OB-GYN:_____ EDC: _____Name of Hospital: _____

Number of Pregnancies: _____ Number of Live Births: _____ Number of Miscarriages: _____

Birth Control Method: _____ Birth Control Pill Name: _____

Finishing /Menopause: _____ Using Hormones? YES or NO If **YES**, Which ones? _____

Date of last PAP smear: _____ Results: _____ Date of last Mammogram? _____

Other concerns or medical problems: _____

MALE MEDICAL HISTORY:

Date of last Prostate exam? _____
Other concerns or medical problems: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

How did you hear about Raphael Medicine & Therapies PC?
◯ Friend/Family Member Name of person who recommended us: _____
◯ Magazine: _____
◯ Newspaper: _____

School: _____ Other: _____

We appreciate your feed back. Thank you for completely filling out this form. If you have any questions prior to your next appointment, please contact Raphael medicine & Therapies PC at (916) 671-1780.

OFFICE HOURS

Mon, Weds, Thurs & Fri 10:00am-Noon, 1:30-5:00pm Except Tues: 1:30pm-5pm

--The office is Closed during lunch hours--