Rocky Mountain Family Physicians, P.C.

PATIENT INFORMATION

Today's Date: _______/_______/_______

Patient's Name: ____
First Middle Initial Last

Address: ____
Street City State Zip

Date of Birth: ____/____/____ Sex: M F Social Security #: __ __ __-__ __-__ __ __ __ Race: ___________ Ethnicity: ____________

Phone #: (_______) -_______-_________ Cell #: (_______) -_______-_________ Work/Other #: (_______) -_______-_________

(2 numbers required)

If patient is under 18, parent's name, address & phone #: ____

____

Emergency contact if not listed above: ____

How did you hear about our practice?

- ☐ Phone Book
- ☐ Insurance Company
- ☐ Patient Referral
- ☐ Doctor Referral
- ☐ Other ______________________

Please INITIAL and SIGN the following statements:

__________ I consent to Rocky Mountain Family Physicians' use and disclosure of my Protected Health Information to carry out treatment, payment and healthcare operations.

__________ I acknowledge that the Privacy Practices of Rocky Mountain Family Physicians was made available for my review.

__________ I have reviewed the Financial Policy and agree to follow the guidelines set forth therein.

__________ I give my permission to release all of my medical-related information to the following person(s):

Name: ______________________________ Relationship: ______________
First Middle Initial Last

Name: ______________________________ Relationship: ______________
First Middle Initial Last

_______ I **DO** / **DO NOT** (circle one) give my permission for Rocky Mountain Family Physicians to leave detailed information regarding my medical care at the following phone number: (_______) -_______-_________.

Signature:____ **Date**______________________

Advance Directives

Date Reviewed: ________________________ None DNR Living Will Durable Power of Attorney HC Proxy

Medications

List all medications you take, prescription and non-prescription, and their dosage   No medications

	Medication	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medication Allergies

Please check if you are allergic to any of the following medications or foods:

Medication	Reaction	Medication	Reaction
Aspirin		Lodine (Etodolac)	
Accupril (Quinapril)		Lopressor (Metoprolol)	
Accutane (Isotretinoin)		Loversol (Contrast Media)	
Adderall (Amphetamine Salts)		Maxipime (Cefepime)	
Advil, Motrin (Ibuprofen)		Micronase (Glyburide)	
Albuterol		Minocin (Minocycline)	
Altace (Ramipril)		Morphine	
Amaryl (Glimepiride)		Naprosyn (Naproxen)	
Atenolol (Tenormin)		Neomycin	
Augmentin (Amoxicillin)		Neptazane (Methazolamide)	
Bactrim (Sulfamethoxazole & Trimethoprim)		Nicobid (Niacin)	
Benadryl (Diphenhydramine)		Omnicef (Cefdinir)	
Biaxin (Clarithromycin)		Omnipen (Ampicillin)	
Buspar (Buspirone)		Oxycodone	
Carafate (Sucralfate)		Pen-Vee K (Penicillin)	
Catapres (Clonidine)		Pepcid (Famotidine)	
Ceclor (Cefaclor)		Percocet (Oxycodone)	
Cefazolin (Ancef)		Persantine (Dipyridamole)	
Cefizox (Ceftizoxime)		Plavix (Clopidogrel Bisulfate)	
Cefzil (Cefprozil)		Polymyxin B	
Celebrex (Celecoxib)		Pravachol (Prevastatin Sodium)	
Cephalosporins		Prevacid (Lansoprazole)	
Cipro (Ciprofloxacin)		Prilosec (Omeprazole)	
Clinoril (Sulindac)		Prinivil (Lisinopril)	
Clozaril (Clozapine)		Prozac (Fluoxetine)	
Codeine		Quinolones	
Conray (Contrast Media)		Ranitidine	
Cortisporin (Otic)		Risperidal (Risperidone)	
Coumadin (Warfarin Sodium)		Ritalin (Methylphenidate)	
Darvon (Propoxyphene)		Septra (Sulfamethoxazole)	
DDAVP (Desmopressin)		Singulair (Montelukast)	
Debrox (Carbamide Peroxide)		Spectracef (Cefditoren)	
Demerol (Meperidine)		Strattera (Atomoxetine)	
Depakote (Valproic Acid)		Sulfa	
Dexedrine (Dextroamphetamine)		Sulfonamides	
Diabeta (Glyburide)		Tagamet (Cimetidine)	
Diamox (Acetazolamide)		Tegretol (Carbamazepine)	
Diflucan (Fluconazole)		Tetanus Toxoid	
Dilantin (Phenytoin Na)		Tetracycline	
Duricef (Cefadroxil)		Ticlid (Ticlopidine HCL)	
Dynapen (Dicloxacillin)		Tofranil (Imipramine)	
Erythromycin		Tylenol (Acetaminophen)	
Flagyl (Metronidazole)		Valium (Diazepam)	
Floxin (Ofloxacin)		Vancomycin	

Medication	Reaction	Medication	Reaction
Glipizide (Glucotrol)		Vasotec (Enalapril Maleate)	
Haldol (Haloperidol)		Vibramycin (Doxycycline)	
Heparin		Wellbutrin (Bupropion HCL)	
Inderal (Propranolol)		Xopenex (Levalbuterol HCL)	
Indocin (Indomethacin)		Xylocaine (Lidocaine)	
Insulin		Zestril (Lisinopril)	
Insulin (Animal)		Zithromax (Azithromycin)	
Keflex (Cephalexin)		Zocor (Simvastatin)	
Klonopin (Clonazepam)		Zovirax (Acyclovir)	
Lasix (Furosemide)		Zyloprim (Allopurinol)	
Latex		Other:	
Levaquin (Levofloxacin)		Other:	
Lipitor (Atorvastatin Calcium)		Other:	

Food Allergies

Food	Reaction	Food	Reaction
Chocolate		Rice	
Corn		Soy	
Eggs		Strawberries	
Iodine or shellfish		Wheat	
Peanuts		Other:	
Red dye		Other:	

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

Condition	Date	Condition	Date	Condition	Date
Alcohol dependence	____/____/____	Diabetes Type I	____/____/____	Hepatitis	____/____/____
Allergies	____/____/____	Diabetes Type II	____/____/____	Kidney stones	____/____/____
Anemia	____/____/____	Diarrhea	____/____/____	Other kidney disease	____/____/____
Angina	____/____/____	Disc degeneration	____/____/____		
Anxiety	____/____/____	Duodenal ulcer	____/____/____	Liver disease	____/____/____
Arthritis	____/____/____	Emphysema	____/____/____	Low blood pressure	____/____/____
Asthma	____/____/____	Esophageal reflux	____/____/____	Migraines	____/____/____
Blood clots	____/____/____	Gallbladder stones	____/____/____	Mixed hyperlipidemia	____/____/____
Broken bones	____/____/____	Goiter	____/____/____	Obesity	____/____/____
Cancer	____/____/____	Gout	____/____/____	Osteoarthritis	____/____/____
Type:		Headache	____/____/____	Osteoporosis	____/____/____
Chronic blood thinner use	____/____/____	Heart attack	____/____/____	Palpitations	____/____/____
Chronic bronchitis	____/____/____	Heart disease	____/____/____	Rheumatoid Arthritis	____/____/____
Chronic Fatigue Synd	____/____/____	Other heart disease	____/____/____	Sciatica	____/____/____
Chronic hepatitis	____/____/____			Seizures/epilepsy	____/____/____
Chronic kidney disease	____/____/____	Heart failure	____/____/____	Sleep apnea	____/____/____
Chronic neck pain	____/____/____	Hepatitis	____/____/____	Stomach ulcer	____/____/____
Chronic sinusitis	____/____/____	High blood pressure	____/____/____	Stroke (CVA)	____/____/____
Circulatory disease	____/____/____	High cholesterol	____/____/____	Thyroid disease	____/____/____
Colotis	____/____/____	Irregular heart rhythm	____/____/____	Tinnitus	____/____/____
Congestive heart failure	____/____/____	Hypertension	____/____/____	Tuberculosis	____/____/____
COPD	____/____/____	Hyperthyroidism	____/____/____	Other:	____/____/____
Crohn's Disease	____/____/____	Insomnia	____/____/____		
Depression	____/____/____	Irritable Bowel Syndrome	____/____/____		

Surgical History

Please check all that apply

Procedure	Date	Procedure	Date	Procedure	Date
Angioplasty		Cholecystectomy		Liver biopsy	
Angioplasty with stent		Colectomy		Open Reduction Internal Fixation	
Appendectomy		Colostomy		Pacemaker	
Arthroscopy knee		Gastric bypass		Small bowel resection	
Back surgery		Hernia repair		Thyroidectomy	
Coronary Artery Bypass Graft		Hip replacement			
Carpal tunnel release		Knee replacement		Tonsillectomy	
Cataract extraction		LASIK			

Other: ____________________

Female Surgical History

	Date		Date
Augmentation mammoplasty	______	Mastectomy	______
Bilateral tubal ligation	______	Myomectomy	______
Breast biopsy	______	Reduction mammoplasty	______
Cesarean section	______	TAH/BSO (Total Abdominal Hysterectomy) / (Bilatereal Salpingo-Oophorectomy)	______
Hysterectomy	______	Vaginal hysterectomy	______
Other: ______	______		

Male Surgical History

	Date		Date
Prostate biopsy	______	Vasectomy	______
TURP (Trans-Urethral Resection of the Prostate)	______	Other: ______	______

Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.

Adopted

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
ADD/ADHD						
Alcoholism						
Allergies						
Alzheimer's disease						
Asthma						
Blood disease						
Heart disease						
Heart disease before 50						
Cancer						
Type: ______						
Depression						
Developmental delay						
Diabetes						
Eczema						
Hearing deficiency						
High cholesterol						
Hypertension						
Inflammatory Bowel Disease						
Kidney disease						
Learning disability						
Mental illness						
Migraines						
Obesity						
Osteoporosis						
Peripheral Vascular Disease						
Seizures/Epilepsy						
Stroke (CVA)						
Other: ______						
Other: ______						

Social History

Do you use tobacco? Yes No Former Type of tobacco used: ______

Packs per day: ______ Years smoked: ______ Year Quit: ______

Other tobacco units per day (cans, cigars, etc.) ______

Units per day: ______ Years used: ______ Year Quit: ______

Do you drink caffeine? Yes No Type: ______ Amount Daily: ______

Do you drink alcohol? Yes No Former

Type: ______ How much per week? ______

Amount: ______ Last drink? ______

Recreational Drug Use? Yes No Former Type: ______

Exercise Frequency: ______ Hours per week: ______ Type: ______

Do you have a preferred pharmacy? Yes No

Pharmacy: ______________________________ Phone Number: ______________________________

Address: ____

Pharmacy: ______________________________ Phone Number: ______________________________

Address: ____

Immunizations

Pediatric immunizations – Please check and indicate the immunization date to all that apply.

	Series #1	Series #2	Series #3	Series #4	Series #5	Date of last
Hepatitis B (HBV)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Diptheria, Tetanus, Pertussis (DTaP)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Haemophilus Influenzae Type B (Hib)	____/____/____	____/____/____	____/____/____	____/____/____		
Polio (IPV, OPV)	____/____/____	____/____/____	____/____/____	____/____/____		
Pneumococcal Conjugate (PCV7)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Pneumococcal Polysaccharide (PCV23)	____/____/____	____/____/____				
Measles, Mumps, Rubella (MMR)	____/____/____	____/____/____				
Varicella (Chicken Pox) (VAR)	____/____/____	____/____/____				
Influenza (LAIV)	____/____/____	____/____/____				____/____/____
Meningococcal (MCV4/MPSV4)	____/____/____	____/____/____				
Tetanus & Diptheria (Td)	____/____/____					____/____/____
Teenage Tetanus, Diptheria, Pertussis (Tdap)	____/____/____					
Hepatitis A (HAV)	____/____/____	____/____/____	____/____/____			
Rotavirus (ROTA)	____/____/____	____/____/____	____/____/____			
Human Papillomavirus (HPV)	____/____/____	____/____/____	____/____/____			
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Adult Immunizations – Please check and indicate the immunization date to all that apply.

	Series #1	Series #2	Series #3	Series #4	Series #5	Date of last
Hepatitis B (HBV)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	
Pneumococcal (PPV23)	____/____/____	____/____/____				
Measles, Mumps, Rubella (MMR)	____/____/____	____/____/____				
Varicella (Chicken Pox) (VAR)	____/____/____	____/____/____				
Influenza (LAIV)	____/____/____	____/____/____				____/____/____
Meningococcal (MCV4/MPSV4)	____/____/____	____/____/____				
Tetanus & Diphtheria (Td)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Adult Tetanus, Diptheria, Pertussis (Tdap)	____/____/____					
Hepatitis A (HAV)	____/____/____	____/____/____	____/____/____			
Varicella Zoster (ZOS)	____/____/____					
Human Papillomavirus (HPV)	____/____/____	____/____/____	____/____/____			
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other: ____________________	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Health Maintenance			Date of last
Lipid Panel	Yes	No	____/____/____
Stool cards for hidden blood	Yes	No	____/____/____
History & Physical	Yes	No	____/____/____
Colonoscopy	Yes	No	____/____/____
Sigmoidoscopy	Yes	No	____/____/____
Influenza Vaccine	Yes	No	____/____/____
Pneumococcal Vaccine	Yes	No	____/____/____
Tetanus Vaccine	Yes	No	____/____/____
DEXA Scan	Yes	No	____/____/____
Gyn Exam	Yes	No	____/____/____
PAP	Yes	No	____/____/____
Mammogram	Yes	No	____/____/____
Breast Exam	Yes	No	____/____/____

Disease Management			Date of last
Abdominal Ultrasound	Yes	No	____/____/____
Cardiac Stress Test	Yes	No	____/____/____
Chest X-Ray	Yes	No	____/____/____
Echocardiogram	Yes	No	____/____/____
EKG	Yes	No	____/____/____
Eye Exam	Yes	No	____/____/____
Foot Exam	Yes	No	____/____/____
Pulmonary Function Test	Yes	No	____/____/____