

RAPHAEL MEDICINE & THERAPIES

9801 Fair Oaks Blvd., Suite 300

Fair Oaks, CA 95628

916-671-1780 Fax 916-844-0083

Please fill out this form with the information of the patient. Please bring this completed form to the next appointment. Thank you.

PATIENT INFORMATION:

TODAY'S DATE: ___ / ___ / ___

NAME _____ PHONE (H) _____ (c) _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
OCCUPATION _____ DATE OF BIRTH _____ AGE _____
E-MAIL: _____ Insurance? NO YES PPO Other: _____

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

<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Gout _____	<input type="checkbox"/> Migraine _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Kidney Disease _____		<input type="checkbox"/> Heart Attack _____
<input type="checkbox"/> Mental Illness _____		<input type="checkbox"/> Glaucoma _____

Briefly describe why you came to the Doctor today:

Main Problems:

1. _____ 2. _____ 3. _____

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:

<input type="checkbox"/> Double or Blurred Vision	<input type="checkbox"/> Asthma / Wheezing	<input type="checkbox"/> Ingestion or Heartburn
<input type="checkbox"/> Eye Infections-frequent	<input type="checkbox"/> Shortness of Breath on exertion – lying flat	<input type="checkbox"/> Persistent Nausea/Vomiting
<input type="checkbox"/> Nose Bleeds – recurrent	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Peptic Ulcers
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Abdominal Pain – chronic
<input type="checkbox"/> Sore Throats – frequent	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Change in Bowel Habits – recent
<input type="checkbox"/> Hay fever/Allergies	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Hoarseness – prolonged	<input type="checkbox"/> Irregular Pulse	<input type="checkbox"/> Constipation
<input type="checkbox"/> Decreased Hearing	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Bloody or Tarry Stools
<input type="checkbox"/> Ear infections – frequent	<input type="checkbox"/> Leg Pain when Walking	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Varicose Veins / Phlebitis	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Failing Vision	<input type="checkbox"/> Loss of Appetite-recent	<input type="checkbox"/> Jaundice/Hepatitis
<input type="checkbox"/> Pneumonia / Pleurisy	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Hernia
<input type="checkbox"/> Bronchitis / Chronic Cough		<input type="checkbox"/> Urine infections – frequent
		<input type="checkbox"/> Painful Urination

(OVER PLEASE)

Blood in Urine
 Overnight Urination – more than 2
 Control in Urination
 Decrease in Force of Urination
 Kidney Stones
 Venereal Disease
 Urethral Discharge
 Chronic Fatigue
 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
 Back Pain – recurrent
 Bone Fracture / Joint Injury
 Gout
 Foot Pain
 Cold Numb Feet
 Rashes
 Hives
 Psoriasis
 Eczema
 Sleeping – difficulty
 Nervousness

Depression
 Memory Loss
 Moodiness – excessive
 Phobias
 Mental Illness
 Chicken Pox
 Polio
 Measles / German Measles
 Rheumatic / Scarlet Fever
 Mumps
 Tuberculosis
 Alcohol (___ oz/week)
 Smoking (___ cig/day)
 Coffee / Tea (___ cups/day)

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

FEMALE MENSTRUAL HISTORY:

Last Period: _____ Age of Onset: _____
 Please describe your cycle: Reg Irreg Heavy Light # of days: _____
 Length of Cycle: _____ Pain/Cramps – use Meds: _____
 Pain/Bleeding After Sex _____
 Number of Pregnancies: _____ Number of Live Births: _____ Number of Miscarriages: _____
 Birth Control Method: _____ Birth Control Pill Name: _____
 Flushing/Menopause Using Hormones? Yes 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?

Friend/Family Member Name of Person who recommended us: _____
 Magazine: _____
 Newspaper: _____
 School: _____
 Other: _____

We appreciate your feedback.

Thank you for filling out this form completely. If you have any questions prior to your next appointment, please contact Raphael Medicine at (916) 671-1780 M-F: 9:00 a.m. – Noon, 1:00 p.m. – 5:00 p.m.

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