The Rizzi Difference
RIZZI GERIATRIC ASSOCIATES

Health History Form

All questions on this form will help your clinician understand your history and medical concerns better. All answers are strictly confidential. Please leave a question blank if you are uncomfortable answering.

Please attach copies of insurance cards. You may also attach a medication list.

Date: _____ **Name**_____

Date of Birth: _____ **Social Security #**: _____

ALLERGIES:

_____

Present Health Concerns:

_____

_____

Are there any changes to either medications or health history?

_____

Medication	Dose	Times per Day	Medication	Dose	Times per day

PERSONAL: Please indicate whether you have any of the following issues with approximate date of illness or diagnosis:

❒Congenital Heart Problems _____ ❒Heart Attack _____ ❒Diabetes _____
❒Hypertension _____ ❒Stroke _____ ❒Cancer _____
❒Bleeding/Clotting Disorder _____ ❒Cancer _____ ❒Depression _____
❒Alcoholism _____ ❒Anxiety _____

Family/History: List any condition in Mother: _____ **Father:** _____

Family History of Diabetes ❒Yes ❒No **Family History of Cancer?** ❒Yes ❒No **Type of Cancer?** _____

HealthCare Maintenance

Date of last flu vaccine: _____ **Date of Pneumonia vaccine:** _____ **Date of Covid-19 vaccine:**_____

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Up to date on dental and eye exams? Yes: _____/No:_____

Surgical History

Operation	Date/Year

Childhood illness: ❒Measles ❒Mumps ❒Rubella ❒Chickenpox ❒Polio ❒Other_____

Social History: ❒Single ❒Married ❒Divorced ❒Separated ❒Widowed Do you smoke? ❒Yes ❒No How many years? _____
How many cigarettes per day?_____ Do you drink alcohol? ❒Yes ❒No How many drinks per week? _____
Occupation: _____ Number of Children: _____

Do you currently have any of the problems below?

Fevers/Chills/Sweats	❒Yes ❒No	Fatigue/Weakness	❒Yes ❒No	Excessive Thirst Or Urination	❒Yes ❒No
Unexplained Weight changes	❒Yes ❒No	Vision Changes	❒Yes ❒No	Difficulty hearing Ringing in ears?	❒Yes ❒No
Dental Problems	❒Yes ❒No	Hay Fever/Allergies	❒Yes ❒No	Chest pain/Discomfort	❒Yes ❒No
Leg pain with exercise	❒Yes ❒NO	Palpitations	❒Yes ❒No	Temporary blindness in one eye	❒Yes ❒No
Temporary Paralysis of one arm	❒Yes ❒No	Temporary Slurring of Speech	❒Yes ❒No	Pain	❒Yes ❒No
Breast Lump/Discharge	❒Yes ❒No	Cough/Wheeze	❒Yes ❒No	Difficulty/Breathing	❒Yes ❒No
Abdominal Pain	❒Yes ❒No	Blood in Bowel Movement	❒Yes ❒No	Nausea/Vomiting	❒Yes ❒No
Night Time Urination	❒Yes ❒No	Leaking Urination	❒Yes ❒No	Muscle/Joint Pain	❒Yes ❒No
#Pregnancies	❒Yes ❒No	#Miscarriages	❒Yes ❒N0	Age at Menopause	❒Yes ❒No
Vaginal Bleeding/Discharge	❒Yes ❒No	Rash or Mole Changes	❒Yes ❒No	Headache	❒Yes ❒No

Dizziness/Lightheaded	❒Yes ❒No	Numbness	❒Yes ❒No	Memory Loss	❒Yes ❒No
Loss of Coordination	❒Yes ❒No	Anxiety/Stress	❒Yes ❒No	Depression	❒Yes ❒No
Frequent Falls	❒Yes ❒No	Do you use a walker/wheelchair	❒Yes ❒No	Difficulty Walking	❒Yes ❒No

Is there anything else in terms of your health that you would like us to know about?

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

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PATIENT PERSONAL INFORMATION FORM

Name: _____ Date of Birth: _____

Social Security Number: _____ Marital Status: _____

Spouse Name: _____ Phone Number: _____

DNR YES or NO (please circle)

EMERGENCY CONTACTS

Emergency Contact Name: _____ Number: _____ Relationship: _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

Power of Attorney? If so please list name and number: _____

Relationship of POA to you?_____

INSURANCE COVERAGE

Insurance: _____ ID NUMBERS: _____ Eff Date: _____

Insurance: _____ ID NUMBERS: _____ Eff Date: _____

(Please attach copies of insurance cards)

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone Number: _____

Do you use mail order? If so, please attach a copy of the ID card with this form or list phone number, mailing address, and any account numbers so that prescriptions can be ordered.

_____

_____