THE RIZZI GROUP
EXPERIENCE THE RIZZI DIFFERENCE

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 ATTACH COPIES OF INSURANCE CARDS. YOU MAY ALSO ATTACH MEDICATION LIST.

Date: _____ Name: _____

Date of Birth: _____ Required Social Security # _____

Allergies and Reactions: _____

Present Health Concerns/Recent Health Changes: _____

_____

Preferred Pharmacy:_____Pharmacy Phone # _____

Medication	Dose	# of Times Per Day	Medication	Dose	# of Times Per Day

Please indicate if you have had any of the following issues with approximate dates of diagnosis.

❑Congenital Heart Problems _____❑Heart Attack _____❑Stroke _____❑Depression _____
❑Hypertension _____❑ Bleeding Disorder _____❑Alcoholism _____ ❑Anxiety_____
❑Diabetes_____ If yes what type ❑1 ❑ 2

Family History: List any conditions in Mother:_____ Father: _____

Family history of diabetes? ❑Yes ❑No History of Cancer? ❑Yes ❑No Type of cancer? _____

Date of last flu vaccine? _____Date of Pneumonia Vaccine? _____Covid 19? _____

Up to date on dental exams? ❑Yes ❑No Up to date on eye exams? ❑Yes ❑No

Surgical History

Operation: Date / Year	Operation: Date/Year

Significant childhood illness: ❑Measles ❑Mumps ❑Rubella ❑Chickenpox ❑Polio ❑Other _____

Social History: ❑Single ❑Married ❑Divorced ❑Widowed ❑

Do you smoke? ❑Yes ❑No If yes - how many years? _____ How many packs per day? _____

Do you drink alcohol? ❑Yes ❑No If yes - how many drinks per day? _____

Occupation: _____ How many children_____

Do you currently have any of the problems below? Check all that apply.

Fevers/chills		Fatigue/Weakness		Excessive urination or thirst	
Weight Changes		Vision Changes		Difficulty Hearing	
Ringing in ears		Allergies		Chest Pain/Discomfort	
Leg pain with exercise		Palpitations		Temporary blindness in one eye	
Dental Problems		Slurring of Speech		Temporary Paralysis of one arm or leg	
Breast Lump/Discharge		Blood in Stool		Changes in bowel movements	
Nausea/Vomiting		Night-Time Urination		Incontinence	
Muscle/Joint Pain		Pain		Skin changes	
Headache		Dizziness		Numbness/tingling	
Memory loss		Lack of coordination		Frequent Falling	
Depression		Anxiety		Insomnia	
Difficulty walking		Major life change		Vaginal bleeding or discharge	

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Do you need help with any of the following activities? Check all that apply.

❑Toilet ❑Feeding or making meals ❑Dressing ❑Grooming ❑Ambulation ❑ Bathing ❑Using the telephone

❑Shopping ❑Housekeeping ❑Laundry ❑Driving ❑Managing Medications ❑Handling Finances

Do you have a POA (Power of Attorney) ❑Yes ❑No Living will ❑Yes ❑No DNR ❑Yes ❑No

Is there anything you would like your healthcare provider to know?

Signature: _____ Date: _____

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