ROCHESTER REGIONAL HEALTH | **Rochester Regional Health**

----- **Patient Demographics** -----

Permission to Communicate

Is there anyone you would allow us to discuss PHI (Protected Health Information) with?

☐ No - Do not discuss PHI with anybody

☐ Yes - Please add/edit persons by writing their name, phone number and any comments, and indicate their relationship to you, using the appropriate 'relation' check box(es).

Name: ______________________________ Phone: ____________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ____________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ____________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ____________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Comment: ______________________________

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This form will cover all RRH locations, with the exception of OB-Gyn, Psychiatry, Pediatrics and Genetics, at which you may be asked to fill out an additional form specific to that practice setting.

Permissions:
☐ Appointment Information.
☐ Billing Inquiries/Statements.
☐ Detailed Message.
☐ Diagnosis and Lab Results.

I have reviewed the above information and agree that it is accurate.

______________________________ ______________
Patient Name Patient Date of Birth

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Personal Representative's Name (Please Print) and Sign Date

______________________________ ______________
RRH Representative Date Time

ROCHESTER
REGIONAL HEALTH

----- Patient Demographics -----

Patient History Form

Name: _____ Birthdate: ____/____/____
Last First Middle Initial Maiden Month / Day / Year

Address: _____ Age: _____ Gender: _____
Street Apt. #

_____ Telephone: Mobile: _____

Home: _____

The name of you primary care provider: _____

Briefly describe your present symptoms: _____

_____

Previous Diagnosis, if any: _____

Previous treatment for this problem: _____

_____

Please list Other Medical Problems: _____

_____

_____

Please list all non-joint surgeries or procedures: _____

_____

_____

Please list any joint surgeries or fractures: _____

_____

_____

Patient History, continued

SYSTEMS REVIEW: Please check if you have any of the following:

Constitutional:
- ☐ Fever: Temperature_____
- ☐ Weight change: _____
- ☐ Sun sensitivity
- ☐ Hair loss/balding

Eyes:
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Red, painful eyes (uveitis)

Ears, Nose, Mouth, Throat:
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Nose bleeding
- ☐ Sinus condition

Cardiovascular:
- ☐ Pain in chest
- ☐ welling in legs (edema)
- ☐ Finger/toe color change in cold
- ☐ Fainting
- ☐ Heart attack
- ☐ Heart failure
- ☐ Palpitations

Respiratory:
- ☐ Shortness of breath at rest
- ☐ Exertional shortness of breath
- ☐ Cough
- ☐ Coughing of blood
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Interstitial lung disease

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Bloating
- ☐ Nausea or vomiting
- ☐ Persistent diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Liver disease/cirrhosis
- ☐ Crohn's/Ulcerative colitis

Genitourinary:
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Frothy urine
- ☐ Kidney disease
- ☐ Kidney Stone

Musculoskeletal:
- ☐ Morning stiffness
- ☐ If so, how long does it last? _____
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ History of gout
- ☐ Chest wall pain
- ☐ Pain to light touch
- ☐ Tendonitis
- ☐ Rotator cuff condition
- ☐ Very flexible

Neurologic:
- ☐ Headache
- ☐ Dizziness (spinning/vertigo)
- ☐ Lightheadedness
- ☐ Numbness/Tingling
- ☐ Seizure
- ☐ Stroke

Skin:
- ☐ Psoriasis
- ☐ Eczema
- ☐ Rash in the sun
- ☐ Facial rash
- ☐ Rosacea
- ☐ Other rash: _____

Hematologic:
- ☐ Low red blood counts (anemia)
- ☐ Low platelets
- ☐ Low white blood cells
- ☐ History of blood clots

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Trouble sleeping
- ☐ Other: _____

Habits:
- ☐ Alcohol use
- ☐ If so, how many drinks per day? _____
- ☐ Cigarette smoking
- ☐ If so, how many cigarettes per day? _____
- ☐ Chewing tobacco
- ☐ Marijuana use
- ☐ Cocaine use
- ☐ Heroin use
- ☐ Other substance use
- ☐ If so, which? _____

Other: Please list any other symptoms below

Patient History, continued

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium, and other supplements, etc.)

Name of Medication	Dose (Include strength & number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Check any you have taken in the past:

☐ Ansaid (flurbiprofen) ☐ Arthrotec (diclofenac + misoprostol) ☐ Aspirin (including coated aspirin) ☐ Celebrex (celecoxib)
☐ Clinoril (sulindec) ☐ Daypro (oxaprozin) ☐ Disalcid (salsalate) ☐ Dolobid (diflunisal) ☐ Feldene (piroxicam)
☐ Indocin (indomethacin) ☐ Lodine (etodolac) ☐ Motrin/Advil (ibuprofen) ☐ Nalfon (fenoprofen) ☐ Naprosyn/Aleve (naproxen)
☐ Oruvall (ketoprofen) ☐ Voltaren (diclofenac) ☐ Tylenol (acetaminophen) ☐ Toradol (ketorolac) Other NSAID: _____

☐ Methotrexate ☐ Hydroxychloroquine ☐ Leflunomide ☐ Sulfasalazine ☐ Azathioprine ☐ Prednisone
☐ Medrol (methylprednisolone)

☐ Enbrel ☐ Humira ☐ Infliximab (Remicade) ☐ Simponi ☐ Cimizia ☐ Orencia ☐ Actemra ☐ Kevzara
☐ Rituximab ☐ Xeljanz ☐ Rinvoq ☐ Olumiant
☐ Anakinra ☐ Benlysta ☐ Saphnelo ☐ Cytoxan (Cyclophosphamide) ☐ IVIG ☐ Cosentyz ☐ Taltz ☐ Stelara
☐ Tremfya ☐ Skyrizi, Otezla

☐ Alendronate (Fosamax) ☐ Risedronate (Actonel) ☐ Ibandronate (Bonvia) ☐ Zolendronic acid (Reclast) ☐ Prolia
☐ Forteo ☐ Tymlos ☐ Evenity, ☐ Raloxifene (Evista)

☐ Allopurinol ☐ colchicine ☐ febuxostat (Uloric)

Please list names of your other physicians and what specialty:

Name of Physician	Specialty
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

List any Family Members with autoimmune conditions and list the condition:

_____

_____