RIVERSIDE RADIOLOGY AND INTERVENTIONAL ASSOCIATES

Name: _____ **Birthdate:** _____ **Date:** _____
*Preferred Contact Method: Home Phone:*_____ *Cell#*_____
Can we Text? yes____ no____
Leave a detailed message on answering machine? YES____ NO____

Email Address: _____

REFERRING PHYSICIAN/GROUP NAME (full name, address, phone#):

_____

_____

PRIMARY CARE PHYSICIAN & OTHER PHYSICIAN/S FOLLOWING CARE (full name, address, phone #):

_____

_____

Preferred Language: _____

Occupation:_____

PHARMACY (NAME/PHONE/CITY):

_____

EMERGENCY CONTACT (NAME/ADDRESS/PHONE/RELATIONSHIP):

_____

SOCIAL HISTORY *Please complete or circle what applies:* Height:_____ Weight: _____
Exposure to HIV/AIDS (TB risk)
Tobacco use: never/current/previous: smoking # pack cig/day:_____, chewing # years: _____ Quit date: _____
Alcohol: never/current/previous: beer/wine/liquor: _____ drinks per day/week/month Quit date:_____
Drug use: marijuana, methamphetamines, cocaine, crack, heroin, other recreational drug: _____
Do you exercise regularly: yes / no Type of activity: _____ How often: _____

In your own words, please explain why your doctor sent you to our practice: _____

_____

When did your symptoms start: _____ **Prior treatment for this problem:** _____

ALLERGIES List Drug: **Reaction:**

SURGICAL HISTORY (Please include year of stents, filters, ports, back injections, births, surgeries

MEDICATIONS (Include any over-the-counter medications, herbs or supplements

Name	Dose (mg)	# times per day
Cont. MEDS:		

REVIEW OF YOUR MEDICAL HISTORY (Please circle conditions which apply to you now or that have been previously treated):

Constitutional	**Genitourinary**
Recent weight loss/gain/fever	Kidney disease/dialysis
Excessive fatigue	Blood in urine
Use of cane/walker/wheelchair	Enlarged prostate
Eyes, Ears, Nose, Throat	Chronic urinary tract infections
Wear glasses/contacts	History of Kidney stones
Glaucoma/cataracts	Urinary incontinence/retention
Blurred vision/double vision/loss of vision	Urostomy
Hard of hearing/hearing aid	Self catheterize
Difficulty speaking/swallowing	**Neurologic**
Chronic sinusitis/sinus headaches	Stroke/TIA
Cardiovascular	Dizziness/balance issues
History of heart attack/chest pain/angina/palpitations	Vertigo/inner ear problems
Pacemaker/Internal Defibrillator	Seizures/convulsions
High blood pressure	Parkinson's/tremors
High cholesterol or triglycerides	Migraines/chronic headaches
Pain in legs with walking (PVD)	Paralysis: _____
Congestive heart failure	Numbness/tingling: _____
Swelling in legs/feet	Memory loss/confusion/Alzheimer's
Irregular heart rate/Atrial fibrillation	**Skin**
Heart valve problems/repair/replacement	Chronic rash/chronic skin ulcer
Blood clot in leg/lungs	Skin disease: _____
Respiratory	Varicose veins
Emphysema/COPD	Change in color or temperature of extremity/location: _____
Asthma/bronchitis	Skin cancer: basal/squamous/melanoma
Sleep apnea/CPAP machine	**Hematologic/Lymphatic/Oncology**
Use of oxygen at night/continuously	Blood clotting disorder: _____
Shortness of breath at rest/with activity	Chronic anemia
Chronic cough/coughing up blood	HIV/AIDS
Musculoskeletal	Cancer: year diagnosed/location/type: _____
Arthritis: osteo/rheumatoid	**Gastointestinal**
Back pain: chronic/acute injury	Liver disease: Hepatitis/Cirrhosis/Jaundice
Gout	Gastric reflux/Indigestion
Muscle weakness: arms/legs	Ulcers/vomiting blood/bloody stool
History of fracture: _____	Frequent diarrhea/constipation
Endocrine	Loss of appetite
Diabetes controlled by diet/medication/insulin	Colostomy/Ileostomy
Thyroid: hypothyroid/hyperthyroid	Other:_____
Other: _____	

FAMILY HISTORY (Mother, Father, Siblings). Circle only those that apply and who it affected:

Cardiovascular	**Neurological**
Heart attack < 55 years of age	Stroke
Abdominal aneurysm	Cerebral aneurysm
Peripheral arterial disease	Any unexplained deaths
Peripheral venous disease/blood clot	**Cancer**
Endocrine	What type: _____
Type II diabetes (adult)	What relative: _____
Type I diabetes (juvenile)	Other:_____
Osteoporosis	