RMI MEDSPA
AND WEIGHT LOSS CENTER

Confidential Patient Information and Health History

Today's Date: _____
Patient Name:_____ DOB:_____
Street Address: _____
City: _____ State: _____ Zip:_____
Phone (H):_____ (Cell):_____
Mobile Phone Provider:_____
Email: _____
Emergency Contact Name: _____ Relationship:_____ Phone:_____
What is your reason for today's visit? _____ Medical History

Symptoms check (√) symptoms you currently have or have had in the past year.

General
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

Gastrointestinal
☐ Appetite Poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding

Eye, Ear, Nose, Throat
☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears

Muscle/Joint/Bone
☐ Arms ☐ Hips ☐ Back ☐ Legs
☐ Feet ☐ Neck ☐ Hands ☐ Shoulders

Cardiovascular
☐ Chest pain
☐ Rapid heart beat
☐ High blood pressure
☐ Poor circulation
☐ Swelling of ankles
☐ Irregular Heart beat
☐ Varicose Veins
☐ Low blood pressure

Skin
☐ Itching
☐ Change in moles
☐ Hives
☐ Bruise easily
☐ Rash
☐ Scars
☐ Sore that won't heal

Genito-Uninary
☐ Blood in urine
☐ Lack of bladder control
☐ Frequent urination
☐ Painful urination

Women only

☐ Abnormal Pap Smear
☐ Bleeding between periods
☐ Breast lump
☐ Extreme menstrual pain
☐ Hot flashes
☐ Nipple discharge
☐ Vaginal Discharge
☐ Painful intercourse
☐ Other
_____

Date of last menstrual period:
_____
Date of last Pap Smear:
_____
Have you had a mammogram?
_____
Are you pregnant?
_____
Number of children:
_____

Men only

☐ Erection difficulty
☐ Breast lump
☐ Lump in testicles
☐ Penis discharge
☐ Sore on penis
☐ Other
_____

Conditions check (√) conditions you have or have had in the past

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Alcoholism
☐ Chicken Pox	☐ HIV Positive	☐ Anemia	☐ Diabetes
☐ Kidney Disease	☐ Anorexia	☐ Emphysema	☐ Liver Disease
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Arthritis
☐ Glaucoma	☐ Migraine Headaches	☐ Asthma	☐ Goiter
☐ Miscarriage	☐ Bleeding Disorder	☐ Gonorrhea	☐ Mononucleosis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Bronchitis
☐ Heart Disease	☐ Mumps	☐ Bulimia	☐ Hepatitis
☐ Pace maker	☐ Cancer	☐ Hernia	☐ Pneumonia
☐ Cataracts	☐ Herpes	☐ Polio	☐ Prostate Problems
☐ Psychiatric Care	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Stroke
☐ Suicide attempt	☐ Thyroid problems	☐ Tonsillitis	☐ Tuberculosis
☐ Typhoid fever	☐ Ulcers	☐ Vaginal Infections	☐ Venereal Disease

Medications	**Dosage**

Allergies	**Medication Sensitivities**

Pharmacy Name:_____
Phone:_____

Please list any serious illness/injuries you have or have had in the past:

_____
_____
_____

Family History Fill in health information about your immediate family. Check if apply.

(√)	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason for hospitalization and outcome

Health Habits

(√)	Habit	Describe your habit
	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Patient Signature:_____ Date:_____
Print Name:_____

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