NRI Medical Services, Inc.
63 Eddie Dowling Hwy, Suite 4
N. Smithfield. RI 02896

Patient History Form

Name (Last, First, MI):	**Home Phone:**	**Today's Date:**
Street Address:	**Work Phone:**	**Date of Birth:**
City, State, Zip:	**Insurance:**	**Marital Status:**
Emergency Contact Person: **Relationship:** **Emergency Contact #:**	**Spouse/Partner's Name:**	**Education:**
Race (Please circle ONE): **1. American Indian or Alaskan Native** **2. Asian** **3. Black or African American** **4. Native Hawaiian or other pacific Islander** **5. White** **6. Other Race: _____**	**Ethnicity (please circle ONE):** **1. Hispanic/Latino** **2. Non-Hispanic/Latino**	**Preferred Language:** **1. English** **2. Another Other (please write below)** **_____**

What brings you to the office today?

1. Annual Exam/Routine Care
2. Problem/Issue (Please describe briefly)
3. I was referred by _____

Current Medications (please list all medications currently taking):

Allergies:

Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what?
Type of reaction:

Past Medical, Hospitalizations and Surgery (List prior illness, hospitalization or surgery).

	Date (Month/Yesr)

NRI Medical Services, Inc.
63 Eddie Dowling Hwy, Suite 4
N. Smithfield. RI 02896

Patient History Form

Family History

Are you adopted? **YES** □ **NO** □

Have your biological family (parents, brothers, sisters) had any of the following:

Diabetes: Yes □ No □	Heart Disease: Yes □ No □	Alcoholism : Yes □ No □	Ovarian Cancer: Yes □ No □
Stroke: Yes □ No □	High BP: Yes □ No □	Breast Cancer : Yes □ No □	Colon Cancer: Yes □ No □
Mental Illness: Yes □ No □	Alzheimer's: Yes □ No □	Glaucoma: Yes □ No □	Migraine headaches: Yes □ No □

Lifestyle/Social History **(please circle the right response)**

Yes No	Do you currently smoke cigarettes? If yes how many cigarettes ____ per week?
Yes No	If you do not currently smoke, did you ever smoke?
Yes No	Do you drink alcohol, if yes how many _____ drinks per week?
Yes No	Do you drink caffeine beverages, if yes which one: _____
Yes No	Do you use recreational drugs, if yes, please write the name of the drug**:** _____
Yes No	Are you satisfied with your social life?
Yes No	Are you satisfied with your spiritual life?
Yes No	Are you satisfied with your sex life?

Sexually Transmitted Infections/Diseases and HIV Risks (please select all that apply)

Number of Partners in your life:	Men_____ Women_____
How Many partners have you had in past year: _____	
Do you have sex with:	□ Men □ Women □ Both
Does your partner have sex with:	□ Men □ Women □ Both
Do you have (check all apply):	□ Vaginal sex □ Oral sex □ Anal sex
Have you ever used street drugs:	If yes, when?
Were any of your partners:	□ Street Drug User □ Infected with HIV/AIDS □ MSM (men having sex with men) □ Hemophiliac

NRI Medical Services, Inc.
63 Eddie Dowling Hwy, Suite 4
N. Smithfield. RI 02896

Patient History Form

Review of Systems

General

□ Weight Loss or Gain
□ Fevers
□ Trouble Sleeping
□ Chronic Fatigue
□ Excessive Bleeding
□ Easy Bruising
□ Abnormal Thirst

Eyes

□ Glasses/contacts
□ Itchy, Red Eyes
□ Vision Problems

Ears

□ Ear Pain
□ Ringing in Ears
□ Hearing Loss

Nose

□ Sinus Problems
□ Nose Bleeds
□ Deviated Septum

Mouth

□ Sore Throat
□ Mouth Sores
□ Bleeding gums

Lungs

□ Coughing Up Blood
□ Shortness of Breath
□ Chronic Cough
□ Blood Clot in the Lungs
□ Painful Breathing
□ Wheezing

Cardiovascular Chest Pain

□ Irregular Heart Beat
□ Ankle/Hand Swelling
□ Easy fatigue
□ Trouble breathing at night

Gastrointestinal

□ Stomach
□ Pain/abdominal pain
□ Frequent Diarrhea
□ Constipation
□ Bloody Stools
□ Nausea/Vomiting
□ Hemorrhoids

Urinary

□ Incomplete Urination
□ Loss of Urine
□ Painful Urination
□ Bloody Urine
□ Kidney stones

Musculoskeletal

□ Muscle Weakness
□ Joint Pains
□ Joint Swelling
□ Clot in Leg Vein

Neurologic

□ Frequent/Severe Headaches
□ Dizziness
□ Seizures
□ Numbness
□ Trouble Walking
□ Fainting Spells
□ Loss of coordination
□ Muscle weakness

Skin

□ Itching
□ Rash
□ Change in color
□ Mole

Emotional

□ Excessive Worry
□ Depression
□ Frequent Crying
□ Unable to sleep

Male

□ Hernia
□ Discharge from penis
□ Pain in testicles
□ Sexual difficulties
□ Methods of contraception:
_____

Female

□ Vaginal itching or burning
□ Vaginal discharge
□ Last menstrual period:_____
□ Last pap smear:_____
□ Sexual difficulties
□ Hot Flashes
□ Night Sweats
□ Methods of contraception:
_____

Breast Problems

□ Breast Pain
□ Breast Lump
□ Nipple Discharge
□ Other Breast Issue

Endocrine

□ Excessively hot
□ Excessively cold
□ Always thirsty
□ Always hungry
□ Thyroid Problem
□ Diabetes

Cardio-Respiratory

□ Heart murmur
□ Varicose veins
□ Blood clots
□ Stroke or stroke symptoms
□ High blood pressure
□ High cholesterol
□ Chronic cough/asthma

Immunization

□ Hepatitis B
□Tetanus
□ MMR (measles, mumps rubella)
□ Other

NRI Medical Services, Inc.
63 Eddie Dowling Hwy, Suite 4
N. Smithfield. RI 02896

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize NRI Medical Services, to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company (ies) and/or physicians.

ASSIGNMENT OF BENEFITS & PAYMENT RESPONSIBILITY

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to NRI Medical Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not covered by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of NRI Medical Services' Notice of Privacy Practices.

ELIGIBILITY WAIVER

I understand that my eligibility for coverage may not be able to be confirmed at this time. I wish to receive medical service from NRI Medical Services. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

RELEASE OF RECORDS

Please complete this section with the names of any person, other than yourself, that you would like to have access to your medical information. If there are no names listed we will only be able to speak with you regarding your healthcare. Please consider if you want family members or friends to have any access to your health information. I authorize the release of my medical information to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and agree to all statements, terms and conditions above.

Signature: _____

Print Name: _____ Date: _____

Signature: _____**Date:**_____