

Ravalli Family Medicine
411 W Main Street
Hamilton, MT 59840

I assume liability for all non-covered charges and deductibles. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and payment policy of Ravalli Family Medicine.

PATIENT CONSENT TO BE TREATED

I consent to being treated as a patient at Ravalli Family Medicine, by the providers and their nursing staff to include the examinations, treatments, diagnostic tests, injections and medications which they believe are advisable and necessary for my care. If I need to be referred to a subspecialty physician, I hereby authorize Ravalli Family Medicine to make my medical information available to the appropriate consultant.

Patient Notification:

I agree that medical information may be left on my answering machine (circle one): Yes No

I agree that medical information may be given to:

Name: _____ Relationship: _____

Phone: _____

Signature of Responsible Person

Date

Relationship

Ravalli Family Medicine Confidential Health History

Patient Name: _____ Date: _____

Age: _____ Birthdate: _____ Date of last physical exam: _____

Physicians you are currently seeing: _____

Referred by: _____

Check conditions you currently have or have had

_ AIDS _ Alcoholism _ Anemia _ Angina _ Anorexia _ Anxiety _ Arthritis _ Asthma _ Bleeding disorders _ Breast lump _ Bronchitis _ Bulimia _ Cancer: _____ _ Cataracts _ COPD _ Chemical Dependency _ Diabetes	_ Depression _ Emphysema _ Epilepsy (seizures) _ Glaucoma _ Gout _ Hay Fever _ Hearing loss _ Heartburn/Acid Reflux _ Heart Disease _ Heart Attack _ Heart murmur _ Hepatitis _ Hernia _ Herpes _ Hiatal Hernia _ High Blood Pressure _ High Cholesterol _ HIV positive	_ Incontinence _ Kidney Disease _ Liver Disease _ Migraine Headaches _ Multiple Sclerosis _ Osteoporosis _ Pacemaker _ Polio _ Prostate Problem _ Psychiatric Care _ Rheumatic Fever _ Scarlet Fever _ Stroke _ Suicide attempt _ Thyroid Problems _ Tuberculosis _ Ulcers Other: _____	Women only: _ Abnormal periods _ Hot flashes Date of last menstrual period: _____ Date of last pap smear: _____ _____ Abnormal: Y or N Have you had a mammogram: Y or N Date: _____ Are you pregnant: Y or N Number of pregnancies: ____ Number of miscarriages: ____ Number of children: _____
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List Medications you are currently taking

Medication	Dose and frequency

Social History: circle or explain as necessary

Marital Status	
Place of employment	
Exercise	Type: _____ Frequency: _____
Smoking	(circle) Previous Current Amount per day: <input type="checkbox"/> none
Chewing tobacco	(circle) Previous Current Amount per day: <input type="checkbox"/> none
Alcohol	Amount per week: <input type="checkbox"/> none
Special diet	(circle) Vegetarian Vegan Low-carb Other: _____ <input type="checkbox"/> none

List Medication allergies (if none please check box below):

None Known

