RUSSAK PERSONALIZED MEDICINE

We care about your health!

5420 S Quebec St. Suite 100
Greenwood Village, Colorado 80111
Phone: 303-221-6797
Fax: 855-225-4866

Floyd B. Russak, M.D.
Beatriz Linn, M.D.
Heather Whiting, P.A.-C.

PATIENT INFORMATION

Name: _____

Preferred Name: _____ Pronoun: _____

Date of Birth _____ Age_____ Sex M or F SSN: _____

Gender Identity: ❑Female ❑Male ❑Transgender Male to Female ❑ Transgender Female to Male ❑ Genderqueer ❑ Not Disclosed

❑Additional gender category not listed: _____

Address: _____ City_____ State _____ Zip_____

Phone 1: _____(home/cell/work) Phone 2: _____(home/cell/work)

Email: _____

Occupation: _____

Marital Status: ❑Married ❑Single ❑Divorced ❑ Separated ❑ Widowed ❑ Partner/Significant Other

Preferred Language: _____

Race: ❑Asian ❑Black ❑ Caucasian ❑ Other **Ethnicity:** ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Not disclosed

How did you hear about us? ❑Google ❑Doximity ❑Facebook ❑Patient in the practice ❑Other_____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____

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Patient name: _____ Patient DOB: _____

INTERNAL MEDICINE HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any of these questions, do not answer them. If you cannot remember specific dates, please provide a year.

Main reason for today's visit: _____
Other concerns: _____
PREFERRED PHARMACY AND LOCATION: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

MEDICATIONS

Please include all prescribed drugs, over the counter drugs and all supplements.

Drug Name	Strength	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

IMMUNIZATION

❑Covid Vaccine (Circle one): Pfizer Moderna Johnson & Johnson
Date(s) administered: _____ & _____

❑Chickenpox	Date:	❑Meningococcus	Date:
❑Flu Shot	Date:	❑MMR	Date:
❑Gardasil/HPV	Date:	❑Tetanus	Date:
❑Hepatitis A	Date:	❑Shingles	Date:

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❑Hepatitis B Date: ❑Pneumonia Date:

Review of systems:

Constitutional Symptoms
- ❑Fever/Chills
- ❑Night sweats
- ❑Weight gain (lbs)
- ❑Weight loss (lbs)
- ❑Exercise intolerance
- ❑Lethargy

Eyes
- ❑Wear glasses/contacts
- ❑Dry eyes/Irritation
- ❑Vision change

Ears/Nose/Throat/Mouth
- ❑Difficulty hearing
- ❑Ear pain
- ❑Frequent nosebleeds
- ❑Sinus problems
- ❑Sore throat
- ❑Bleeding gums
- ❑Snoring/Mouth breathing
- ❑Dry mouth
- ❑Mouth ulcer
- ❑Teeth abnormalities
- ❑Runny nose
- ❑Sinus pressure
- ❑Itching
- ❑Hives
- ❑Frequent sneezing

Cardiovascular
- ❑Chest pain on exertion
- ❑Arm pain on exertion
- ❑Shortness of breath when walking
- ❑Shortness of breath when lying down
- ❑Palpitations
- ❑Known heart murmur
- ❑Light-headed on standing
- ❑Ankle swelling

Respiratory
- ❑Cough
- ❑Wheezing
- ❑Shortness of breath
- ❑Sleep apnea

Gastrointestinal
- ❑Abdominal pain
- ❑Nausea/Vomiting
- ❑Constipation
- ❑Change in appetite
- ❑Black or tarry stools
- ❑Frequent diarrhea
- ❑Vomiting blood
- ❑GERD

Genitourinary
- ❑Urinary loss of control
- ❑Difficulty urinating
- ❑Increased urinary frequency
- ❑Incomplete emptying

Musculoskeletal
- ❑Muscle aches/weakness
- ❑Arthralgias/joint pain
- ❑Back pain
- ❑Swelling in the extremities
- ❑Neck pain
- ❑Difficulty walking
- ❑Cramps
- ❑Osteoporosis
- ❑Fractures

Dermatologic
- ❑Abnormal mole
- ❑Jaundice
- ❑Rash/itching
- ❑Dry skin
- ❑Growths/lesions
- ❑Changes in hair/nails
- ❑Psoriasis

Neurological
- ❑Loss of consciousness
- ❑Weakness
- ❑Numbness
- ❑Seizures
- ❑Dizziness
- ❑Frequent/severe headaches
- ❑Migraines
- ❑Restless legs
- ❑Tremor
- ❑Gait dysfunction
- ❑Paralysis

Psychiatric
- ❑Depression
- ❑Sleep disturbances
- ❑Feeling unsafe in relationship
- ❑Restless sleep
- ❑Alcohol abuse
- ❑Anxiety
- ❑Hallucinations
- ❑Suicidal thoughts
- ❑Mood swings
- ❑Memory loss
- ❑Dementia

Endocrine
- ❑Fatigue
- ❑Increased thirst
- ❑Hair loss
- ❑Increased hair growth
- ❑Cold intolerance

Hematologic/Lymphatic
- ❑Swollen glands
- ❑Easy bruising
- ❑Excessive bleeding
- ❑Anemia
- ❑Blood clotting disorder

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Past Medical History

❑**ADD/ADHD**
❑**AIDS/HIV**
❑**Abuse/Domestic Violence**
❑**Allergies/Hay fever**
❑**Anemia**
❑**Anesthesia Complications**
❑**Anxiety Disorder**
❑**Arthritis**
❑**Asthma**
❑**Autism Spectrum Disorder**
❑**Birth Defects or Inherited Disease**
❑**Bladder or Kidney Problems**
❑**Hypertension**
❑**Infertility/Pregnancy issues**
❑**Kidney Disease/Stones**
❑**Liver Disease**
❑**Lung Disease**
❑**MRSA Exposure**
❑**Meniere's Disease**
❑**Mental Disorder**
❑**Blood Diseases/Transfusion**
❑**Breast Cancer/Problem**
❑**COPD**
❑**Cancer Type: _____**
❑**Chicken Pox**
❑**Chronic Ear Infections**
❑**Congestive Heart Failure**
❑**Constipation**
❑**Coronary Artery Disease**
❑**Depression**
❑**Developmental or Behavioral Disorders**
❑**Diabetes**
❑**Muscle, Joint, or Bone Problems**
❑**Obesity**
❑**Osteoporosis**
❑**Pulmonary Embolism**
❑**Seizures/Epilepsy**
❑**Skin Problems**
❑**Stroke**
❑**Difficulty Swallowing**
❑**Diverticulitis**
❑**Ear or Hearing Problems**
❑**Eating Disorder**
❑**Eczema**
❑**Endometriosis**
❑**Fibromyalgia**
❑**GI Problems**
❑**Gout**
❑**Headaches**
❑**Heart Disease/Problems**
❑**High Cholesterol**
❑**Thyroid Problems**
❑**Tuberculosis**
❑**Vision or Eye Problems**

❑**Other**
_____

Past Surgical History

	Surgery	Reason	Year	Hospital
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

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Family Health History

Relation	Alive (Circle one)	Current Age or Age Deceased	Health Problems (Circle)
Maternal Grandmother	YES or NO		Alcoholism Arthritis Depression Cancer: _____ Diabetes Heart disease Hypertension Other_____
Maternal Grandfather	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Paternal Grandmother	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Paternal Grandfather	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Mother	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Father	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Brother/Sister (Circle one)	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other_____
Brother/Sister (Circle one)	YES or NO		Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Other _____

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WOMEN ONLY: OBSTETRIC AND GYNECOLOGICAL HISTORY (Men: see bottom of page)

Last PAP Date:_____ Abnormal: NO YES

Last Mammogram Date:_____ Abnormal: NO YES

Age started menopause: _____

HPV Vaccine: NO YES

Sexually active: NO YES

Sexual problems: NO YES

STIs/STDs: NO YES

Pregnancies:

Full term _____

Miscarriage _____

Abortion _____

Ages of children: _____

Current birth control method: _____

Date of last period:_____ UNKNOWN APPROXIMATE DEFINITE

Flow: LIGHT MODERATE HEAVY

Duration of flow (days): _____

Frequency of cycle: _____

Period monthly: NO YES

Age at first period: _____

Men Only:

Last Prostate Examination: _____ Outcome of Examination: _____

Erectile Dysfunction: NO YES

Sexual Active: NO YES

Vasectomy: NO YES If yes when: _____

Ages of children (if any): _____

Do you have or have you ever been diagnosed with any sexually transmitted diseases: NO YES

If yes, what were they and when: _____

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Patient name: _____ Patient DOB: _____

Social History

Education:

- ❑**Less than 8th grade**
- ❑**High School**
- ❑**2 years of college**
- ❑**4 years of college**
- ❑**Post graduate**

Caffeine:

- ❑**None**
- ❑**Occasional**
- ❑**Moderate**
- ❑**Heavy**

Number per day_____

Alcohol:

- ❑**None**
- ❑**Occasional**
- ❑**Moderate**
- ❑**Heavy**

How many drinks per week _____

Do you currently use recreational or street drugs: NO YES

If yes please list: _____

Do you use Tobacco: NO YES _____ years Age started: _____

Past history of Tobacco use: NO YES _____ years Year quit: _____

- ❑**Cigarettes _____ pks/day**
- ❑**Vape/ E-Cigarettes**
- ❑**Chew _____ per day**
- ❑**Cigars _____**

Exercise Level:

- ❑**None**
- ❑**Occasional exercise**
- ❑**Moderate exercise**
- ❑**High level exercise**

Please add any other information about your health that you would like your provider to know:

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Patient name: _____ Patient DOB: _____

Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking much more slowly than usual; Or the opposite – fidgety or restless	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems have these problems made it for your work, take care of things at home, or get along with other people?

□ **Not difficult at all** □ **Somewhat difficult** □ **Very Difficult** □ **Extremely Difficult**

Generalized Anxiety Disorder 7 (GAD-7)

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not At All	Several Days	More Than Half the days	Nearly Every Day
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid, as if something awful might happen	0	1	2	3

If you checked off any problems have these problems made it for your work, take care of things at home, or get along with other people?

□ **Not difficult at all** □ **Somewhat difficult** □ **Very Difficult** □ **Extremely Difficult**

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Patient name: _____ Patient DOB: _____

Consent to Treatment

I, _____, voluntarily consent to receive any medical and health care services by Dr. Floyd Russak, MD, Dr. Beatriz Linn, MD, Dr. Jordan Walker, DO, Heather Whiting, PA-C, and staff, including diagnostic procedures, examinations, treatments, and laboratory work.

Financial Responsibility and Assignment of Benefit

It is your responsibility to know your insurance benefits (co-pay, referral, deductible and coverage.) Your insurance plan is a contract between you and your insurance company. It is impossible for our office to be familiar with all insurance plans. If you have any questions, please consult your insurance company directly.

I agree to pay all charges for medical and health care services and Laboratory services not covered by my insurance company. I understand that if I no-show or cancel an appointment within less than 24 hours, I am subject to a fee per appointment missed.

In case of default payment, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.

I certify that I read this form and understand its contents.

_____

Signature of patient (or legally Authorized Person)

Date: _____

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Patient HIPAA Acknowledgement and Consent Form

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give my permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the provider, or an agent of the provider or an independent physician's office may contact me for the purposes of scheduling necessary follow up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide and email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications or the email or text address I have proved or you or your EBO servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but are not limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. (You may opt out of this communication at any time.)

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Release of Information

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to claims under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

_____ _____

Patient/Representative Signature Date

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Patient name: _____ Patient DOB: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM PREVIOUS/CURRENT PROVIDERS

Patient's Name: _____
Date of Birth: _____
Phone Number: _____
Are records filed under another name? _____

INFORMATION TO BE RELEASED BY: REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER

Organization/Person Name: _____

Address, City, State, Zip: _____

Phone:_____ Fax: _____

INFORMATION TO BE RELEASED TO:

RPM Family Health
5420 S. Quebec St #100
Greenwood Village, CO 80111
Phone: (303) 221-6797
Fax: (855) 225-4866

TYPE OF MEDICAL INFORMATION REQUESTED:

o Complete medical record abstract (includes 5 years of chart notes, most recent labs/pathology & diagnostic imaging reports)

o Cancer records

o Behavioral Health records

o My health information only for the following date(s):

o Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above-named person or organization.

Patient signature: _____ Date: _____