RUSSAK PERSONALIZED MEDICINE
We care about your health!

PATIENT INFORMATION

Name:_____.

Preferred Name:_____ **Pronoun:**_____.

Date of Birth: _____ **Age:**_____ **Sex:** M or F **SSN:**_____.

Gender Identity: ☐ **F**emale ☐ Male ☐ Transgender ☐ Genderqueer ☐ Not Disclosed

Address: _____ **City:**_____ **State:** _____ **Zip:**_____.

Phone: _____ (home/cell/work) **Phone:**_____(home/cell/work)

Email:_____.

Occupation:_____.

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

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

Preferred Language: _____.

How did you hear about us? ☐ Google ☐ Facebook ☐ Patient in practice ☐ Instagram ☐ Tik Tok ☐ 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

MEDICATIONS

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

Drug Name	Strength	Frequency

Immunizations

☐ Covid Vaccine (circle one): Pfizer Moderna Johnson & Johnson **Date(s) Administered:** _____& _____.

☐ Chickenpox- Date:_____ ☐ Meningococcus- Date:_____ ☐ Flu Shot-Date:_____.

☐ Gardasil/HPV - Date:_____ ☐ MMR – Date:_____ Tetanus – Date:_____.

☐ Hepatitis A- Date:_____ ☐ Shingles-Date:_____ Hepatitis B- Date:_____.

☐ Pneumonia- Date:_____ ☐ RSV- Date:_____.

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Patient Name:_____ **Patient DOB:**_____.

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
- ☐ Seizures/Epilepsy
- ☐ Meniere's Disease
- ☐ 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 Disorder
- ☐ Diabetes
- ☐ Muscle, Joint, or Bone Problems
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ MRSA Exposure
- ☐ 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
- ☐ Lung Disease
- ☐ Skin Problems
- ☐ Mental Disorder
- ☐ Other _____.

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital

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Patient Name:_____ **Patient DOB:**_____.

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

Ear/Nose/Throat/Mouth
- ☐ Difficulty breathing
- ☐ Ear pain
- ☐ Frequent nosebleeds
- ☐ Sinus problems
- ☐ Sore Throat
- ☐ Bleeding gums
- ☐ Snoring mouth breathing
- ☐ Dry mouth
- ☐ Mouth Ulcers
- ☐ Teeth abnormalities
- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing

Cardiovascular
- ☐ Psoriasis
- ☐ Chest pain on exertion
- ☐ Arm pain on exertion
- ☐ Shortness of breath when walking
- ☐ Shortness of breath lying down
- ☐ Palpitations
- ☐ Known heart murmur
- ☐ Light-headed on standing
- ☐ Ankle swelling
- ☐ Changes in hair/nails

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Sleep Apnea

Gastroinestinal
- ☐ 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
- ☐ Growth/lesion

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
- ☐ Hallucination
- ☐ 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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Patient Name:_____ **Patient DOB:**_____.

Family Health History

Relation	**Alive (Circle One)**	Current Age or Age Deceased	Health Problems (Circle)
Maternal Grandmother	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Maternal Grandfather	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Paternal Grandmother	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Paternal Grandfather	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Mother	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Father	Yes or No		Alcoholism, Arthritis Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Brother/Sister (Circle one)	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:
Brother/Sister (Circle One)	Yes or No		Alcoholism, Arthritis, Depression, Diabetes, Heart disease, Hypertension, Genetic Disease, Cancer Other:

RUSSAK PERSONALIZED MEDICINE
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Patient Name:_____ **Patient DOB:**_____.

OBESTETRIC AND GYNECOLOGICAL HISTORY (MEN: see bottom of page)

WOMAN ONLY:

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

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

If yes, what were they and when:_____.

Pregnancies: Full term _____ Miscarriages _____ 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: Normal / Abnormal

Erectile Dysfunction: NO YES

Sexually Active: NO YES

HPV Vaccine: NO YES

Vasectomy: NO YES If yes when:_____.

Ages of children (if any): _____.

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

If yes, what were they and when:_____.

RUSSAK PERSONALIZED MEDICINE

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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/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:

☐ None ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

PLEASE ADD ANY OTHER INFORMATION ABOUT YOUR HEALTH YOU WOULD LIKE YOUR PROVIDER TO KNOW:

RUSSAK PERSONALIZED MEDICINE
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Patient Name: _____ **Patient DOB:** _____.

Patient Health Questionnaire (PHQ9)

	Over the past 2 weeks, how often have you been bothered by any of these 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 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 slower 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 any of the problems made it hard for you to work, take care of 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 controlling or 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 any of the problems made it hard for you to work, take care of 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. Jordan Walker, DO. Heather Whiting, PA-C, Sky Ridge Resident Team, and staff. Including diagnostic procedures, examinations, treatments, and laboratory work.

Financial Responsibility and Assignments of Benefits:

It is your responsibility to know your insurance benefits (co-pay, referral, deductible, co-insurance, 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 contact your insurance company directly.

I agree to pay all the charges for medical and health 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 payments, 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

RUSSAK PERSONALIZED MEDICINE
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Patient Name:_____ Patient DOB:_____.

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 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 purpose 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 an 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 provided or you or your EOB 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).

_____ _____.

Patient Signature Date

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Patient Name:_____ Patient DOB:_____.

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 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 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 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 consent.

_____ _____.

Patient/Representative Signature Date

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Patient Name:_____ **Patient DOB:**_____.

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

Patients 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:

- Complete medical record abstract (including 5 years of chart notes, most recent labs/pathology & diagnostic imaging report).
- Cancer Records
- Behavioral Health Records
- My health information only for the following date(s):
- 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-name person or organization. **To ensure compliance with HIPAA and applicable record retention policies, charges will be assessed for the reproduction and distribution of medical records provided directly to patients.**

Patient Signature:_____ Date:_____.