RYICAL®

We Prescribe Peace of Mind®

Ryical Medical Consulting, LLC
515 Madison Avenue
Suite 3800 B
New York, NY 10022
T. 212.804.8805
www.Ryical.com

Demographics/History

Provided information is considered personal and confidential and will only be shared with permission. Although inquiries may not seem pertinent to your current issue the information may be important to effectively communicate with your healthcare provider.

Please print.

Client name:

Age:

Date of Birth:

Marital status:

M F

Ethnicity:

Religion (Limitations that would prevent you from having surgery, taking blood products, etc.):

First language/preferred language:

Dominant Hand:

Name/relationship/contact information of person providing information (if other than client):

How did you hear about Ryical Medical Consulting, LLC?

Brief history of why you are seeking assistance:

Brief history of your current medical condition, if any:

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Email address:

May we send personal information to this email address?

Best contact phone number:

Alternate contact phone number:

Cellular number:

May we text personal information to this number?

Emergency contact (Name, Relationship, Phone):

Home address:

Mailing address if different than home:

Primary care physician (Name, Address, Phone, Fax, Email if available):

Specialist physicians (Name, Specialty, Address, Phone, Fax, Email if available):

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Height and Weight:

Recent weight changes:

Allergies to medications and reactions: (for example: Penicillin: rash)

Allergies to non-medications and reactions (for example: Latex: rash or Shellfish: throat itching):

Anti-anxiety medications with dose and frequency:

Mental health history:

Medical history (Any problems diagnosed by a doctor):

Medications with dose and frequency:

Non-prescription medications and supplements:

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Surgical history (year, reason):

History of general anesthesia:

History of local anesthesia:

Problems with anesthesia (personal and family and list any adverse reactions):

History of excessive bleeding:

History of blood transfusions:

Additional hospitalization history (year, reason):

Chemotherapy history:

Radiation history:

Genetic testing history:

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Family medical history (non-cancer):

Family cancer history:

Childhood illnesses (measles, mumps, rubella, chickenpox, rheumatic fever, polio):

Screening/testing history (date and result)

Colonoscopy:

Upper endoscopy:

PAP:

DRE:

PSA:

Mammogram:

Sonogram:

MRI:

CT scan:

PET scan:

Last doctor performed breast exam:

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Social history

Exercise (type and frequency):

High salt or high fat diet:

Caffeine intake per day or week:

Alcohol use per day or week:

Cigarette use per day or week:

Number of years:

Age when quit:

Chewing tobacco:

Nicotine patch or gum:

Recreation or street drugs:

Needle drugs:

Steroid/muscle enhancing supplement use:

History of Hepatitis, HIV, STDs:

Reside/live at home with:

Type of residence:

Number of flights of stairs used daily:

Pets (approximate weight):

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Drive a vehicle:

Glasses:

Contact lenses:

Hearing aids:

Dentures:

Wheel chair, cane, walker:

Physical limitations:

Type of work:

Supplemental Oxygen:

CPAP Use and Settings:

Other assistive device:

Living will/ Advance directive/ healthcare proxy:

Pharmacy information #1

Name:

Address:

Phone number:

Pharmacy information #2

Name:

Address:

Phone number:

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OB/GYN history

Menarche (age of first period):

Menopause (age):

Period has a regular cycle:

Total number of pregnancies:

Total number of live births:

Age at first live birth:

Total time breast-feeding:

Sexually active:

Hot flashes:

Tubal ligation:

IUD:

Oral contraceptive pills:

Hormone replacement therapy (past or present):

Routine self-breast exams:

Urology history

Testicular exam:

Prostate exam:

ED:

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The information in the next section is optional, however, physicians often request it. Completing this portion of the form is recommended if you plan to have a Ryical Medical Consultant help you to fill out your medical forms or assist you with scheduling appointments.

Occupation/Employer:

Employer phone #:

Employer/Business address:

Social Security number:

Primary Insurance

ID number:

Group number:

Phone number:

Name on plan with their SS# if different than self:

Secondary Insurance

ID number:

Group number:

Phone number:

Name on plan with their SS# if different than self:

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By signing below I confirm that I have provided Ryical Medical Consulting, LLC (herein RMC), and its constituents, with accurate information. I understand that I am responsible for the personal and medical information provided and, as such, RMC cannot be held accountable or liable for omitted or incorrect information. I understand that this form is not a legal medical document. I have been given the opportunity to ask questions and make comments all of which were answered and addressed to my satisfaction and understanding.

Client name (please print):

Signature:

Date:

If the client is a minor, please complete the following:

Client's name (please print):

Name of parent/Legal guardian: (please print):

Relationship to client:

Signature:

Date: