HEALTH HISTORY UPDATE for current patients

*Name*_____ *Age:* _____

This form will update your medical information. Please complete it and bring it to your appointment. It should take about 10 minutes to fill out, and it may be easier if you have your calendar and medicines nearby. This information will help your doctor provide you with the most appropriate care. Thanks for completing this form.

Please indicate your main health concerns:

_____

_____

_____

CURRENT MEDICATIONS, VITAMINS, AND SUPPLEMENTS:
(Include prescriptions, over the counter, herbal, or dietary supplements)
If you prefer to bring a list or your pill bottles to the visit that is fine.

MEDICATION	DOSE	TAKEN HOW OFTEN
For example:		
Calcium		
Multivitamin		
Vitamin D		
Aspirin		
Pain medications (Motrin, Advil, Aleve, Tylenol)		

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES:
List all medications that you are allergic to or don't tolerate. Please describe the reaction (rash, swelling, nausea):

_____

_____

_____

REVIEW OF SYSTEMS

Please check the symptoms you are currently experiencing or have recently experienced.

GENERAL:

- Excessive sleepiness
- Sleeplessness (Insomnia)
- Fever
- Night sweats/hot flashes
- Weight gain
- Weight loss
- Loss of appetite
- Fatigue

SKIN:

- Rash
- Dryness
- Nail problems
- Itching
- Hair problems
- Lumps/Wart or mole changes
- Bruises

HEAD-EYES-EARS-NOSE-THROAT:

- Double vision/blurry vision
- Diminished vision
- Itchy eyes
- Hearing loss/ wearing hearing aides
- Ear clogging
- Ringing in ears
- Jaw pain/ TMJ
- Sinus congestion/Stuffy nose
- Nasal drip (runny nose)
- Bloody nose
- Hoarseness
- Sore throat

NODES AND GLANDS:

- Swollen/Painful glands
- Excessive thirst
- Cold intolerance
- Heat intolerance

BREASTS:

- Lumps or cysts
- Breast pain prior to menstruation
- Nipple discharge

LUNGS:

- Shortness of breath
- Chronic cough
- Coughing up blood

CARDIOVASCULAR:

- Chest discomfort
- Irregular pulse (skip beats)
- Leg pain with walking
- Swelling in feet or ankles
- Dizziness or fainting spells
- Decreased exercise tolerance

GASTROINTESTINAL:

- Difficulty swallowing/ pain with swallowing
- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Hemorrhoids
- Blood in stool

GENITO-URINARY:

- Loss of bladder control (incontinence)
- Blood in urine
- Pain/Burning with urination
- Increase frequency of urination
- Awakening at night to urinate

MUSCULOSKELETAL:

- Muscle weakness
- Joint pain/swelling/stiffness
- Difficulty walking due to joint or muscle pain
- Leg cramps

NEUROLOGICAL/PSYCHIATRIC:

- Memory loss
- Loss of coordination
- Numbness/tingling
- Headache
- Loss of balance
- Anxiety
- Depression

MEN ONLY:

Are you currently/recently sexually active?
Decreased sex drive/Low libido
Difficulty getting an erection or maintaining an erection
Difficulty starting to urinate
Feeling of incomplete bladder emptying
Dribbling after urination
Decreased urinary stream
Discharge from penis

WOMEN ONLY:

If you still get your period:
Date last normal menstrual cycle began:
Are your Periods regular?
Do you get painful menstrual cramps?
How long does your period last?
Do you get spotting between Periods?

Are you currently or recently sexually active?
Pain with Intercourse?
Loss of sex drive/Other sexual difficulties?
Do you use any type of Birth Control? What Type?

Have you gone through menopause? Age at Menopause?

Have you tried to get pregnant unsuccessfully?
Have you sought care for infertility?
Number of pregnancies:
Numbers of live births:
Numbers of miscarriages:
Numbers of abortions:

SOCIAL HISTORY:

Do you drink beverages containing caffeine?_____

If so, what do you drink and how often?_____

Do you smoke?_____

Do you drink alcohol?_____

If so, how much and how often_____

Do you use illegal recreational drugs?_____

What do you do for exercise?_____

Describe your diet: _____

If you are working, what sort of work do you do?_____

PREVENTION

Vaccinations (if given to you by another provider)	Date of most recent
Tetanus (every 10 years)	_____
Pertussis/Tetanus (Tdap/Adacel once in adulthood)	_____
Pneumonia (once if over 65)	_____
Shingles (Zostavax) (once if over 60)	_____
Colonoscopy (over 50, sooner if family history)	_____
Women only	
Papsmear/gyn exam	_____
Bone density test (dexa; for postmenopausal)	_____
Mammogram	_____

Where else have you gone for medical care in the past year?

For example:

ER (emergency room)/Urgent Care
Cardiologist
Dermatologist
Eye doctor (ophthalmologist)
Gynecologist
Neurologist
Orthopedist
Urologist
Others:

_____

_____

_____

_____

_____

_____

Please list any surgeries you have had in the past year/since your last physical:

Date Type of surgery

In addition to anything noted above please list any acute or chronic medical problems that interfere with your daily life.

Year of Onset Illness/ Condition Treatments

FAMILY HISTORY: Please note major health problems of your parents, grandparents, siblings, and children that occurred in the past year/since your last physical. If you check a box please indicate which member of your family has or had the condition.

For example:

Diabetes
Cancer
High blood pressure
High cholesterol
Heart attack
Stroke

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS MEDICAL FORM. Please remember to bring this form to your visit.