MEDICAL HISTORY UPDATE DATE: _____

PATIENT NAME: _____D/O/B:_____

Chief Complaint/HPI:_____

_____

_____

_____

Age:_____ Ht.: _____ Wt.: _____ Occupation:_____

Allergic to Medicine? Reaction?:_____

_____

When was your last medical exam? _____By Whom:_____

Past Medical History/Review of Systems:

Childhood diseases?_____

Accidents/injuries?_____

Any surgery & when?_____

Any hospitalizations & when?_____

Have you had any of the following diagnosis or symptoms now? **Please circle & explain**.

Skin, hives	Y	N	_____
Head, headaches	Y	N	_____
Eye problems	Y	N	_____
Ear	Y	N	_____
Nose, sinus	Y	N	_____
Throat, mouth	Y	N	_____
Thyroid, neck	Y	N	_____
Lungs, asthma, bronchitis	Y	N	_____
Heart-chest pains, other	Y	N	_____
Circulatory, bleeding	Y	N	_____
GI, stomach, bowel, liver	Y	N	_____
OB, GYN, Prostrate	Y	N	_____
Kidney, urinary, bladder	Y	N	_____
Bones, joints, arthritis	Y	N	_____
Autoimmune, Endocrine	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
High Blood Pressure	Y	N	_____
Anxiety, depression	Y	N	_____
Neurology	Y	N	_____

Family History Please list all relatives who have definite illnesses; if deceased, please give reason and age at the time of death. _____ _____

_____ _____ _____

Do you or did you smoke? Y N If so, how much? If quit, when? _____

Do you or did you do street drugs? Y N If so, how much? If quit, when? _____

Do you or did you drink alcohol? Y N If so, how much? If quit, when? _____

Do you or did you coffee/caffeine? Y N If so, how much? If quit, when? _____

Do you have allergies? Y N seasonal? Y N food? Y N animals? Y N