UPDATED MEDICAL HISTORY

Please take a moment to fill out this medical history form so that we can update your medical history.

Today's Date:__________________

Patient's Full Name:____

DOB:_________________________

UPDATED MEDICATION LIST – SINCE YOUR LAST VISIT

Date Started	Medication and Dose	Directions	Date Stopped	Reason for Taking	Prescribed By

(Continue on Page 3)

UPDATED MEDICAL HISTORY – SINCE YOUR LAST VISIT

1. Please list any active medical problems for which you are currently being treated since your last visit (such as hypertension, diabetes, high cholesterol, asthma, and seizures.)

____

____

2. Please list your surgeries with the date(s) – Since your last visit:

____

____

3. Please list your non-surgical hospitalizations with the date(s) – Since your last visit:

____

____

4. Please list any major accidents or injuries with the date(s) – Since your last visit:

____
____

5. Please list any new allergies or adverse side effects to medications:

____
____

PREVENTION INFORMATION – SINCE YOUR LAST VISIT

Flu Vaccine________________ Hepatitis B Vaccine________________Pneumonia Vaccine_______________
Hepatitis A Vaccine______________Tetanus Vaccine________________Gardasil Vaccine________________
Meningitis Vaccine____________________________PPD/TB Test___________________________________

SOCIAL HISTORY/LIFESTYLE – SINCE YOUR LAST VISIT

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Occupation____
Do you smoke or use nicotine products? ☐Yes ☐No How many years?_________________________
Cigarettes (# Packs/day)__________ Cigars__________ Pipe__________ Chew Tobacco____________
Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products? ☐Yes ☐No
If yes, which ones and how often?____
Do you take something to help you sleep? ☐Yes ☐No If yes, what and how often?_________________
Do you restrict your diet in any way? ☐Yes ☐No If yes, how?_____________________________________
Do you drink alcohol? ☐Never ☐Occasionally ☐Daily

UPDATED FAMILY HISTORY – SINCE YOUR LAST VISIT

Have you had any changes in your family history since your last visit?

____
____

OTHER

Do you have Advance Directives?

1. Living Will? ☐Yes ☐No
2. Durable Power of Attorney for Health Care? ☐Yes ☐No

Do you have special concerns for this physical exam?

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____
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