Patient Name_____

Date of Birth_____

Today's Date_____

Existing Patient Personal and Family History Update

What is your reason for visiting the office today?_____

MEDICATION

Do you have any allergies to medications? ❑ Yes ❑ No

If yes, please list:_____

Do you take medications regularly? ❑ Yes ❑ No If so, please list below (use back if needed)

MEDICATION	DOSE/FREQUENCY/ROUTE	NOTES

UPDATES TO MEDICAL AND FAMILY HISTORY *Since last visit have you had any new:*

Medical problems:

Surgeries or Procedures:

Changes to Family History:

Other:

HEALTH SCREENING *When was the date of your last….*

Colonoscopy	Bone Density	Cholesterol Check
Mammogram	Dermatology visit	Dental visit

Who is your primary care physician and when did you last see them?

SYSTEMS REVIEW *In the past month have you had any of the following?*

GENERAL
- ❑ Weight change
- ❑ Fatigue
- ❑ Night sweats

NEUROLOGIC
- ❑ Headache
- ❑ Dizziness
- ❑ Memory loss

MUSCLES/JOINTS
- ❑ Joint pain: site_____
- ❑ weakness
- ❑ swelling of joints: site _____
- ❑ swelling of legs

SKIN
- ❑ rash/redness
- ❑ new lesion

DIGESTIVE
- ❑ Nausea/vomiting
- ❑ abdominal pain
- ❑ constipation
- ❑ Diarrhea
- ❑ Blood in stool

GENITOURINARY
- ❑ Pain with urination
- ❑ Incontinence
- ❑ Blood in urine
- ❑ Frequent urge to go

GYNECOLOGIC
- ❑ vaginal discharge/itching
- ❑ pelvic pain
- ❑ abnormal bleeding
- ❑ heavy bleeding
- ❑ pain with intercourse

PSYCHOLOGICAL
- ❑ Difficulty sleeping
- ❑ Excessive worries
- ❑ Lack of interest in activity
- ❑ decrease interest in sex

HEART/LUNGS
- ❑ Chest pain
- ❑ shortness of breath
- ❑ palpitations
- ❑ wheezing

HEAD/NECK
- ❑ hearing difficulty
- ❑ vision problems
- ❑ hoarse voice
- ❑ difficulty swallowing