

# Annual Patient History Update

**Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Update on Family History** – Have any close relatives (parents, siblings or children) been recently diagnosed with any medical problems? \_\_\_\_\_

List all allergies to medications:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications and doses (mg) you are taking, including vitamins, Calcium, aspirin, herbs and supplements. Use back if necessary.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any hospitalizations, surgery or procedures in the past year?  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you experienced any new life changing experiences this year?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Health Habits:** (circle your Answer)  
**Alcohol:** YES NO Amount \_\_\_\_\_  
**Tobacco use:** YES NO Amount \_\_\_\_\_  
 Would like help quitting \_\_\_\_\_  
**Exercise:**  
 Daily 3-4 times a week Rarely Never

**Have you had any of these in the past year? When?**  
 Tetanus Shot \_\_ Flu Shot \_\_ Pneumonia vaccine \_\_  
 Hepatitis \_\_ Other Vaccine \_\_\_\_\_  
 Bone Density \_\_ Colonoscopy \_\_ Prostate Exam \_\_  
 PAP \_\_ Mammogram \_\_  
 Eye Exam \_\_ Eye Care Physician: \_\_\_\_\_

**Review of Systems** Please check YES or NO to each problem

| YES NO   | YES NO  | YES NO   |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Change in mole or lump | <input type="checkbox"/> <input type="checkbox"/> Diarrhea or constipation    | <input type="checkbox"/> <input type="checkbox"/> Breast pain, lump or discharge                           |
| <input type="checkbox"/> <input type="checkbox"/> Ear problem            | <input type="checkbox"/> <input type="checkbox"/> Sexual difficulty           | <input type="checkbox"/> <input type="checkbox"/> Night sweats   |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness              | <input type="checkbox"/> <input type="checkbox"/> Bloody or black stool       | <input type="checkbox"/> <input type="checkbox"/> Hot flashes  |
| <input type="checkbox"/> <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> <input type="checkbox"/> Blood in urine              | <input type="checkbox"/> <input type="checkbox"/> falls or balance problem                                 |
| <input type="checkbox"/> <input type="checkbox"/> Disturbance in vision  | <input type="checkbox"/> <input type="checkbox"/> Overnight urination         | Last menstrual period _____  |
| <input type="checkbox"/> <input type="checkbox"/> Nose Bleeds            | <input type="checkbox"/> <input type="checkbox"/> Lump or pain in testicles   | <input type="checkbox"/> <input type="checkbox"/> Taking hormones-<br>Including birth control or estrogen? |
| <input type="checkbox"/> <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> <input type="checkbox"/> Bruise more easily          | Other comments or concerns?<br>_____<br>_____<br>_____<br>_____<br>_____                                   |
| <input type="checkbox"/> <input type="checkbox"/> Sore throat            | <input type="checkbox"/> <input type="checkbox"/> Tremor/hands shaking        |  |
| <input type="checkbox"/> <input type="checkbox"/> Excessive thirst       | <input type="checkbox"/> <input type="checkbox"/> Muscle weakness             |  |
| <input type="checkbox"/> <input type="checkbox"/> Cough                  | <input type="checkbox"/> <input type="checkbox"/> Numbness/tingling sensation |  |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> <input type="checkbox"/> Headaches-more frequent     |  |
| <input type="checkbox"/> <input type="checkbox"/> Choking                | <input type="checkbox"/> <input type="checkbox"/> Swollen or painful joints   |  |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain             | <input type="checkbox"/> <input type="checkbox"/> Back pain                   |  |
| <input type="checkbox"/> <input type="checkbox"/> Irregular pulse        | <input type="checkbox"/> <input type="checkbox"/> Rash/skin problem           |  |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles         | <input type="checkbox"/> <input type="checkbox"/> Sleeping problem/insomnia   |  |
| <input type="checkbox"/> <input type="checkbox"/> Loss of appetite       | <input type="checkbox"/> <input type="checkbox"/> Depression                  |  |
| <input type="checkbox"/> <input type="checkbox"/> Trouble swallowing     | <input type="checkbox"/> <input type="checkbox"/> Agitation/nervousness       |  |
| <input type="checkbox"/> <input type="checkbox"/> Heartburn              | <input type="checkbox"/> <input type="checkbox"/> Suicidal thoughts           |  |
| <input type="checkbox"/> <input type="checkbox"/> Change in bowel habit  | <input type="checkbox"/> <input type="checkbox"/> Currently seeing therapist  |  |
| <input type="checkbox"/> <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> <input type="checkbox"/> Unexplained weight loss     |  |

Date Reviewed by Physician \_\_\_\_\_ Physician Signature \_\_\_\_\_