



PATIENT HEALTH HISTORY UPDATE

Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____ Patient No.: _____

Please check any problems you have had, **SINCE YOUR LAST VISIT.**

Or, check this box if **NO** problems.

CONSTITUTIONAL

- Fever
- Chills
- Headache
- Significant Weight Change
- Unexplained Hair Loss

GASTROINTESTINAL

- Abdominal Pain
- Diarrhea/Constipation
- Nausea/Vomiting
- Heartburn
- Mucous/Blood in Stools

EYES

- Blurred Vision
- Double Vision
- Glaucoma

ENMT

- Ear Infection
- Sore Throat
- Sinus Problems
- Difficulty Swallowing

GENITOURINARY

- Difficulty Urinating
- Painful Urination
- Frequent Urination
- Blood in Urine

NEUROLOGICAL

- Tremors
- Dizziness
- Numbness
- Arm/Leg Weakness

CARDIOVASCULAR

- Chest Pain
- High Blood Pressure
- Swelling in ankles/feet

MUSCULOSKELETAL

- Joint Pain
- Neck Pain
- Back Pain

PSYCHOLOGICAL

- Depression/Anxiety
- Unusual Stress

RESPIRATORY

- Wheezing
- Cough
- Shortness of Breath

ALLERGIC/IMMUNOLOGIC

- Allergies
- Hay Fever

HEMATOLOGIC/LYMPHATIC

- Swollen Gland
- Blood Clotting Problems
- Unexplained Bruising

ENDOCRINE

- Thyroid Problem

SKIN (INTEGUMENTARY)

- Rash
- Ulcers on Feet

FAMILY HISTORY

Has any family member been diagnosed with a major illness since your last visit? N ____ Y ____

If yes, who? _____

What illness? _____

SOCIAL HISTORY

Tobacco Use? N ____ Y ____ # packs per day _____
 Alcohol Use? N ____ Y ____ How much? _____
 Caffeine Use? N ____ Y ____ How much? _____
 Exercise Regularly? N ____ Y ____ What kind? _____ How often? _____

PATIENT'S SIGNATURE

DATE

PHYSICIAN'S SIGNATURE