



PATIENT HISTORY UPDATE

Name: _____ Birthdate: ___/___/___ Today's date: ___/___/___

Please list all **Prescription Medications/Over-the-counter/Vitamins/Supplements** you are currently taking:

Medication Name	Strength	Frequency	Reason for medication	Refill needed?
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

List any **Medication Allergies** you may have:

Medication: _____ Reaction: _____

SOCIAL HISTORY

Do you use Tobacco? Never Current user Former user Type: Cigarettes Chew Pipe Other: _____
 Units/day: .5 1 1.5 2 Other: _____ Years used: _____ Years quit: _____

Do you drink Alcohol? No Yes Formerly How many drinks per week? 1-3 4-6 7-10 Other: _____

Do you drink Caffeine? No Yes Type of Caffeine: Soda Coffee Energy drinks Other: _____ Amount/day: _____

PAST MEDICAL HISTORY

Please list any **Recent Surgeries or Hospitalizations** you have had **SINCE YOUR LAST VISIT:**

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____

Please list and **New Medical Conditions or Injuries SINCE YOUR LAST VISIT:**

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Alzheimer's Disease Y N
 Asthma Y N
 Blood Disease Y N
 Depression Y N
 Cancer Y N
 CVA(stroke) Y N
 Diabetes Y N

Who? _____

High Cholesterol Y N
 High Blood Pressure Y N
 Mental Illness Y N
 Migraines Y N
 Osteoarthritis Y N
 Osteoporosis Y N
 Other: _____ Y N

Who? _____

