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UPDATED PATIENT MEDICAL HISTORY

YOUR NAME:_____ SEX:_____ DATE OF BIRTH:_____

REASON FOR VISIT

What problems are you seeing the doctor for today? (Please list all problems, how long, and how often they have troubled you.)

ANY UPDATES TO FAMILY HISTORY

List the ages and health problems of the people listed. If they are no longer living, what did they die from?

FATHER _____
MOTHER_____
BROTHERS AND SISTERS _____
_____
SPOUSE_____
CHILDREN_____
Does anyone in your family have these problems?
_____ Heart Problems _____ Prostate Cancer
_____ Breast Cancer _____ Skin Cancer
_____ Colon Cancer _____ Diabetes

FEMALE HISTORY

Have you stopped having regular periods? _____ When? _____
Do you consider your periods normal? _____
When was your last mammogram? _____

SOCIAL HISTORY

Any changes in your occupation? _____
Are you smoking? _____If so, how much? _____
Do you drink alcohol? _____If so, how much? _____
Has a family member ever hurt you? _____
Do you exercise regularly? _____
Do you wear a seatbelt? _____

ANY NEW ALLERGIES TO MEDICATIONS AND FOOD?

ALLERGY YOUR REACTION ALLERGY YOUR REACTION

_____
_____
_____

MEDICINES YOU TAKE

List all medications you take. This includes medicines from a doctor and medicines you buy yourself at a store.

Medicine _____	Dosage _____
Medicine _____	Dosage_____
Medicine _____	Dosage _____
Medicine _____	Dosage _____
Medicine _____	Dosage_____
Medicine _____	Dosage_____
Medicine _____	Dosage _____
Medicine _____	Dosage _____
Medicine _____	Dosage_____
Medicine _____	Dosage _____

REVIEW OF PROBLEMS

Do you have any of the following problems?

Weight gain or loss _____	Heartburn _____
Tiredness _____	Stomach Pain _____
Sadness _____	Nausea _____
Not Sleeping _____	Diarrhea or Constipation _____
Dizziness _____	Knee or Hip Pain _____
Headaches _____	Tingling _____
Eye or Ear Problems _____	Urination Problems _____
Nose or Sinus Problems _____	Abnormal Periods _____
Breast Problems _____	Gonorrhea or Chlamydia _____
Chest Pain _____	Cough _____
Breathing Problems _____	

OTHER COMMENTS

Do you have any other comments for the doctor or nurse?

_____

_____

_____

_____

_____

Patient Signature _____ Date_____

Physician Reviewed _____ Date _____