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**

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