Updated Medical History

Date: _______________

Name: ____ Date of Birth: ______________________
Last First Middle

PLEASE PRINT AND COMPLETE ALL NEW INFORMATION SINCE LAST WELLNESS EXAM

This information is for use by the physician as part of your confidential medical record.

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

If married, spouse's name: ______________________________

Recent Births

Children's names and ages: ____

NEW Allergies to Medications, X-Ray Dyes, or Other Substances ☐No ☐Yes

If yes, please list name of medicine and type of reaction______________________________

NEW Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	*Dose*	*Drug Name*	*Dose*	*Drug Name*	*Dose*

Pharmacy Name and Phone:

Please List and Supply the Dates of Any New Procedures Since Your Last Visit

Operations: ____________________ ____________________ ____________________

Hospitalizations other than for surgery: ______________________________

Immunizations you've have had since your last visit **(outside this office)**______________________________

NEW Family History Has any member of your immediate family (including parents, grandparents, and siblings) ever had the following?

Illness	*Which family member*	*Age when diagnosed*
Cancer (describe type)		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc)		
Drug or alcohol addiction		
Glaucoma		
Bleeding disease		
Other		

Prevention Please circle answers.

Do you wear seat belts? **Yes No** Do you wear a bike helmet? **Yes No N/A**

Do you exercise regularly? **Yes No** If yes, type, duration and number of times per week?____________

Do you smoke? **Yes No** If yes, how many packs per day? ____________

Do you drink alcoholic beverages? **Yes No** If yes, how much per week? ____________

Do you drink coffee/tea? **Yes No** If yes, how many cups per day? ____________

Is there a gun in your home? **Yes No** If yes, do you keep it unloaded and out of children's reach? **Yes No**

Do you use drugs? (marijuana, cocaine, crack, etc.) **Yes No** If yes, explain: ____________

Have you ever engaged in any activity which has put you at risk of getting AIDS? **Yes No** If yes, explain: ____________Do you wish to be tested for AIDS? **Yes No**

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? **Yes No**

Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by your partner? **Yes No N/A**

Do you ever feel afraid of your partner? **Yes No N/A**

Do you have a "living will?" **Yes No** Do you have a donor card? **Yes No** Do you wear sunscreen? **Yes No**