



Medical History Update

Please check if you are now or recently experiencing any of the following:

- Constitutional: Anorexia/Bulemia Weight loss Weight gain Fatigue Sweating Fever
- Eyes: Vision loss Double vision Spots
- Ear/Nose/Throat: Ringing in ear Earache Sore throat Bleeding gums Congestion
- Cardiac: Chest pain Palpitations Swelling (location _____)
- Respiratory: Wheezing Cough Shortness of breath
- GI: Constipation Diarrhea Bloating Black or bloody stools
- GU: Urine: Frequency Urgency Burning Incontinence Pain
- Periods: Cramps Irregular Heavy Spotting PMS
- Vagina: Dryness Itching Discharge Painful intercourse
- Menopause: Hot flashes Night sweats Other _____
- Muscle: Joint pain Muscle cramps Weakness
- Skin: Rash Dryness Lesions Acne Moles
- Breast: Lump Discharge Pain Skin changes
- Neuro: Headaches Dizziness Tremors Weakness Seizures
- Psych: Depression Anxiety Insomnia Memory loss Moodiness
- Endo: Excess thirst Hair loss Excess hair Cold/heat intolerance Excess urination
- Lymph: Bruising Nosebleeds Swollen glands

Do you smoke? Yes No

Is anyone physically or emotionally hurting you? No Yes, Who? _____

Please list current **PRESCRIBED** medications you are taking along with the strength and dose.

MEDICATION	STRENGTH	DOSE

Continued on reverse side

Please list current **OVER THE COUNTER** medications you are taking along with the strength and dose.

MEDICATION	STRENGTH	DOSE

1st day of last period? _____

What concerns do you want to discuss at today's appointment? _____

What symptoms do you want to discuss with the provider? _____

Other physician/provider visits since last time here (for same condition)? Yes No

If yes, (who/where): _____

Do you have specific requests for:

- New Medication(s): _____
- Refills: _____
- Vaccinations: _____
- Referrals: _____
- Tests: _____
- Completion of forms: _____
- School or work release: _____
- Other: _____

SIGNATURE: _____ DOB : _____ DATE : _____