

Medical Care Group

Name _____

Patient Information Update

Chart Number _____ Date _____

1) Since your last visit to our office, were you admitted to the hospital? (circle answers) Yes No

If yes, please give details (hospital, dates, reason) _____

2) Since your last visit, have you had any medical tests? Yes No

If yes, please circle those that apply. Blood work ECG X-rays CT("CAT") scan MRI
DEXA(bone) Colonoscopy Mammogram Pap smear Other _____

Please list where and when (approximate date) _____

3) Since your last visit to our office, have you seen a specialist? Yes No If yes, who, which specialty and

when? _____

4) Since your last visit to our office, have you started any new prescription medicines? Yes No

If yes, please list name, dose, frequency and condition _____

5) Have you started any new OTC (over-the-counter) meds, herbal supplements, vitamins or minerals? Yes No

If yes, please list name, dose, and indication _____

6) Since your last visit, have you had any immunizations (i.e. flu shot)? Yes No

Specify _____

7) Since your last visit to our office, have you developed any new allergies, or had a bad reaction to any medicine

or food? Yes No Specify _____

8) Has anything changed with the health of your immediate family members (including parents, siblings,

children)? Yes No Specify _____

9) Do you get regular exercise? Yes No If yes, _____ minutes, _____ times per week .

10) Do you wear seatbelts in the car? Always Sometimes Never

11) How would you rate your nutrition? Excellent Good Fair Poor Plan to improve? Yes No

12) Do you smoke cigarettes or chew tobacco? Yes No If so, how much? _____ packs/tins per day/week.

If yes, do you want to discuss quitting at a future visit? Yes No

13) How much alcohol do you drink in a typical week? _____ drinks per day / week (circle one).

14) Has anyone been concerned about the amount of alcohol you drink? Yes No If so, who? _____

(please turn over)

- 15) Have you had sex with more than one partner within the past year? Yes No Same-sex partner (ever) Y N
- 16) Have you RECENTLY been experiencing:
- Difficulty falling or staying asleep? Yes No If yes, details _____
- Often felt sad or depressed or hopeless? Yes No If so, why, _____
- Debilitating headaches? Yes No If yes, has a doctor ever diagnosed migraines? Yes No
- Dizziness, fainting spells or blackouts? Yes No If yes, have you had these before? Yes No
- Blurred or double vision? Yes No If yes, for how long? _____
- Sudden or rapid loss of hearing? Yes No If yes, do you have ringing in the ears also? Yes No
- Frequent or severe nosebleeds? Yes No
- New or persistent cough? Yes No If yes, do you have allergies? Yes No
- Chest pain, pressure or discomfort? Yes No If yes, how long does it typically last? _____
- Shortness of breath? Yes No If yes, any idea of possible causes? _____
- Heart palpitations or pounding? Yes No If yes, how much caffeine in a typical day? _____
- Nausea or vomiting? Yes No If yes, describe how often _____
- Constipation or diarrhea? Yes No If yes, describe how often _____
- Frequent abdominal pain or discomfort? Yes No If yes, describe _____
- Recent blood in your stool? Yes No If yes, do you have hemorrhoids? Yes No
- Recurrent bladder or kidney infections? Yes No
- Recent blood in your urine? Yes No
- Recent difficulty starting or stopping urination? Yes No
- Waking at night to urinate? Yes No Is this new? Yes No _____ Times per night _____
- Pain or weakness in your arms? Yes No Legs? Yes No Details _____
- Numbness or tingling in your arms? Yes No Legs? Yes No Details _____
- Recent severe back pain? Yes No If yes, describe _____
- New skin rash, lump or sore? Yes No If yes, describe _____
- 17) Do you have other issues to discuss today, if time allows? Yes No

 Signature _____ Date _____