

**PATIENT HEALTH HISTORY UPDATE**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Patient No.: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check any problems you have had, **SINCE YOUR LAST VISIT.**  
 Or, check this box  if **NO** problems.

**CONSTITUTIONAL**

- Fatigue
- Significant Weight Change
- Unexplained Hair Loss

**GASTROINTESTINAL**

- Heartburn
- Acid Reflux

**GENITOURINARY**

- Kidney Problems

**CARDIOVASCULAR**

- Chest Pain
- High Blood Pressure
- Swelling in Ankles or Feet

**NEUROLOGICAL**

- Dizziness
- Fainting

**MUSCULOSKELETAL**

- Difficulty Walking
- Pain in Legs When Walking

**RESPIRATORY**

- Shortness of Breath
- Sleeping on More Than One Pillow

**ENDOCRINE**

- Thyroid Problem
- Diabetes

**HEMATOLOGIC/LYMPHATIC**

- Unexplained Bruising
- Bleeding Disorder

**SKIN (INTEGUMENTARY)**

- Rash Related to Medications
- Ulcers on Feet

**ALLERGIC/IMMUNOLOGIC**

- I Do Not Get an Annual Flu Shot

**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**