PATIENT UPDATE FORM

Office use: Acct #_____

CIRCLE PLEASE: Are you here for a NEW Problem OR Follow-up for an existing condition ?

CIRCLE PLEASE: Were you INJURED DUE TO: Auto Injury Work Injury Not Applicable

If so, explain_____

GIVE PHOTO IDENTIFICATION & INSURANCE CARDS TO RECEPTIONIST PLEASE.

PATIENT'S NAME _____**Birthdate:** **Today's date**_____

Address:_____Age_____Weight_____ Height_____

- **SUPPLY ONLY the BEST phone #s to contact you and authorize us to leave messages (HIPAA)**

1) ( )_____ **2)** ( ) ___ _____ **3)** ( ) _____

- **Email address:**_____@_____ **Work #** ( )_____

Current MEDICAL INFORMATION

Today, you are here for (circle): Follow up on an Existing Condition OR a New Problem?
Briefly explain: _____

Your MEDICAL Doctor's name/address/phone_____
_____(___)_____

PHARMACY & phone_____( ) _____

List ALLERGIES & reactions you have to Medication:_____
_____

_____
LIST any RECENT or MAJOR surgery (procedure and date of surgery)
_____

- Please **CIRCLE** any **that apply** !!

_____**AIDS/HIV**
_____**BLEEDING DISORDERS**
_____**BROKEN BONES/FRACTURES**
_____**HEPATITIS**
_____**LIVER PROBLEMS**
_____**HIGH BLOOD PRESSURE**
_____**HEMMOROIDS**
_____**STROKE** when_____
_____**TUBERCULOSIS(TB)** .
_____**ULCERS**
_____**HEART PROBLEMS**
Specify:_____(heart attack, irregular heart beat, heart failure)
_____**LUNG PROBLEMS** Specify:_____(pneumonia, emphysema, asthma)

_____**ANEMIA**
_____**COLITIS**
_____**DIABETES**
_____**KIDNEY PROBLEMS**
_____**GLANDULAR PROBLEMS**
_____**HISTORY OF CANCER**
_____**SEIZURES**
_____**THYROID PROBLEMS**
_____**TUMORS**
_____**PHLEBITIS/varicose veins**
_____ **PULMONARY/EMBOLISM/blood clots**

Any other MEDICAL PROBLEMS that aren't listed above, please list below:

_____

Signature _____ Date_____

CONTINUE TO NEXT PAGE

MEDICATION DOSE REASON FOR MEDICATION HOW LONG ON THIS?

_____

_____

Please list all Vitamins or Supplements that you routinely take: (attach a separate paper if necessary):

REVIEW OF SYSTEMS: ***COMPLETE each section below :***

1) General Recent weight gain/ loss Chills Fever Weakness/Fatigue NONE
Other_____

2) Eyes: Vision Change Glasses/Contacts Cataracts Glaucoma NONE
Other_____

3) Ears,Nose Throat: Loss of hearing Ear Ache or Infection Ringing in Ear Sinus Problems
Horseness NONE Other:_____

4) CardioVascular: Chest Pain Swelling in Legs Shortness of Breath Palpitations NONE
Other;_____

5) Respiratory: Shortness of Breath Wheezing/Asthma Frequent Cough NONE Other?
Other:_____

6) Gastrointestinal: Heartburn Acid Reflux Nausea/vomiting Abdominal Pain NONE
Other_____

7) Skin : Rash Skin Ulcers Abnormal scars Open Sores NONE
Other:_____

8) Neurological Headaches Faintness/Dizziness Numbness, tingling, loss of sensation in body NONE
Other_____

9) Psychiatric Depression Nervousness Anxiety Mood Swings Bipolar NONE
Other_____

10) Endocrine Excessive thirst or hunger Hot/Cold intolerance Hot Flashes NONE
Other_____

11) Hematological: Easy Brusing Easy Bleeding Anemia NONE
Other _____

Patient/Guardian's SIGNATURE_____Date:_____

PHYSICIAN'S REVIEW AND SIGNATURE: _____