

ANNUAL HEALTH UPDATE

Name: _____ Date of Birth: _____
 Reason for Visit: _____ Date of Visit: _____
 Current prescription medications, vitamins or supplements: _____

Allergies: _____

PAST MEDICAL HISTORY

Please check if **YOU** have or had the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart attacks |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic fever / heart disease |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Strokes | <input type="checkbox"/> Sexually transmitted disease(s) |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer type: _____ | | |
| <input type="checkbox"/> Injuries | <input type="checkbox"/> Broken bones details/date: _____ | <input type="checkbox"/> Head concussions or injuries details/date: _____ |
| <input type="checkbox"/> Hospitalization(s) _____ | | |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Local | <input type="checkbox"/> Regional |
| <input type="checkbox"/> Operations | <input type="checkbox"/> General | <input type="checkbox"/> Other / Unknown |
| <input type="checkbox"/> Car accident(s) date(s): _____ | | |
| <input type="checkbox"/> Other serious conditions _____ | | |

FAMILY HISTORY

Please check if **any blood relative** has ever had:

- | | |
|--|--|
| <input type="checkbox"/> Breast cancer (who: _____) | <input type="checkbox"/> Colon cancer (who: _____) |
| <input type="checkbox"/> Other cancers (_____) | <input type="checkbox"/> Mental illness (anxiety / depression / other) |
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Osteoarthritis / Gout |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart disease / heart attacks | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Other _____ |

RELATIVE	IF LIVING		IF DECEASED	
	Age	Health	Age	Cause of Death
Father				
Mother				
Sibling(s) M/F				
M/F				
Spouse				
Children M/F				
iii M/F				

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed Other
 Are you sexually active? Yes No If yes, with males with females with both
 Are you living with your spouse/partner? Yes No Is your sex life satisfactory? Yes No
 Are there dependents at home? Yes No Children / Grandchildren / Other
 Do you drink alcohol? Yes No How much? _____ How often? _____
 Do you smoke now? Yes No How much? _____ How often? _____
 Did you ever smoke? Yes No Amount / Quit date? _____
 Do you use drugs? Yes No How much / often? _____
 Do you have pets? Yes No Please list: _____
 Do you exercise regularly? Yes No Do you have an advance directive? Yes No
 Are you employed? Full-time Part-time Unemployed Occupation: _____
 Time lost due to health reasons: In past 6 mos? _____ past yr: _____ past 5 yrs: _____

(OVER PLEASE)

REVIEW OF SYSTEMS

Please **CIRCLE** if you have any of the following **NOW** and answer questions with blanks:

GENERAL: Fever Chills Weight loss Weight gain Fatigue Appetite change Insomnia

SKIN: Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation

HEAD/EYES/EARS/NOSE/THROAT: Headaches Eye disease or injury Glasses Contacts

Double vision Blurry vision Glaucoma Itchy eyes Runny nose Sneezing

Nosebleeds Chronic sinus trouble Ear disease Poor hearing Dizziness

NECK: Stiffness Enlarged glands Thyroid trouble

RESPIRATORY: Frequent colds Spitting up blood Cough Asthma/Wheezing Emphysema

Difficulty breathing Shortness of breath Pain with breathing Pleurisy Pneumonia

CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering

Difficulty walking two blocks Swelling of hands / feet / ankles High blood pressure

Heart murmur Valvular heart disease Palpitations

DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting

Vomiting blood Gallbladder disease Liver trouble Hepatitis Cramping Gas/Bloating

Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools

GYNECOLOGICAL: Age periods started: ____ How long do periods last? _____

Frequency of periods: Every _____ days Painful periods PMS Menopause

Birth control _____ Hysterectomy (date / reason: _____)

Number of pregnancies _____ Number of abortions/miscarriages _____

Date of last period _____ Last Pap _____ Normal / Abnormal

Date of last mammogram _____ Normal / Abnormal

Have you ever had an STD? No Yes _____

List all hormones taken (past/present) _____

GENITOURINARY: Kidney stones Loss of urine Frequent urination Burning/painful urination

Blood in urine Vaginal / Urethral discharge Circumcised? Y / N Testicular pain / swelling

MUSCULOSKELETAL: Varicose veins Weakness of muscles or joints Difficulty walking

Pain or swelling of joints Back pain (where? _____ chronic? Y / N)

Scoliosis Pain in buttock/calves while walking, relieved with rest

ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold

Current wt _____ Current height _____ Dry skin Coarse hair

HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots

NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis

Weakness Convulsions/Seizures Under a lot of stress Anxiety Depression Bipolar

Suicide Attempts Disinterest in usual activities Hopelessness Worthlessness

Poor concentration Anorexia Bulimia

PREVENTIVE: Last tetanus shot _____ Last flu shot _____

Last pneumonia shot _____ Last screen for colon cancer _____

Last prostate exam _____ Last PSA _____

Name & number of your dentist _____

Patient's signature: _____ Date: _____

Reviewed by: _____ Date: _____