Patient Information Update

Name_____
ID Number_____

1) Since your last visit to our office, were you admitted to the hospital?
Yes □ No □
If yes, please write where and when:_____

2) Since your last visit to our office, have you had any medical tests?
Yes □ No □
If yes, please check any that apply:

□ Mammogram (breast xray)	□ Pap smear (for women)	□ Colonoscopy
□ Blood work	□ X-rays	□ ECG / EKG (heart)
□ Vision	□ DEXA (checks for bone loss, or osteoporosis)	
□ MRI	□ CT ("CAT" scan)	□ other _____

List where and when you had the tests done_____

3) Since your last visit to our office, have you developed any new allergies or had a bad reaction to a medication or food?
Yes □ No □
If yes, describe: _____

4) Since your last visit to our office, have you seen a specialist (such as a doctor for diabetes, heart, kidneys, cancer, eyes, gynecology, etc.)?
Yes □ No □
If yes, who did you see and when?

Name	Approx. Date
Name	Approx. Date

5) Since your last visit to our office, have you had any vaccinations (shots)?
Yes □ No □
If yes, check the shots you received:
□ flu □ tetanus □ pneumonia
□ other - please list:_____

6) Since your last visit to our office, have you started any new prescribed medications?
Yes □ No □
If yes, list: _____
_____

(please turn over)

7) Since your last visit to our office, have you started any new over-the-counter medications (such as Advil, Tylenol, aspirin, Tums, etc.), **herbal medications** (such as St. John's Wort, etc.), **vitamins or minerals** (such as Vitamin C, or Calcium, etc.)?
Yes □ No □
If yes, please list: _____
_____

8) Has anything changed with the health of your family members (including parents, siblings, or children)?
Yes □ No □
If yes, please list: _____

9) Do you regularly use:

Seat belts	Sometimes □	Always □	N/A □
Car seats for children in your car	Sometimes □	Always □	N/A □

10) Do you have a working smoke alarm in your home <u>and</u> have you changed the batteries within the past 6 months?
Yes □ No □

11) Do you exercise at least 20-30 minutes 3 times per week?
Yes □ No □

12) Do you find it difficult keeping your balance or have you fallen recently?
Yes □ No □

13) Do you sometimes have difficulty getting to the restroom "in time," and/or do you sometimes have urinary accidents when sneezing or coughing?
Yes □ No □

14) Do you feel sad, "down," depressed or hopeless?
Yes □ No □

15a) If you smoke or chew tobacco, have you thought about quitting?
Yes □ No □
15b) If you've thought about quitting, would you like help to do so?
Yes □ No □

16) Has anyone been concerned about your drinking of alcohol or use of drugs?
Yes □ No □

17) Do you have a gun in the home?
Yes □ No □

18) Have you had sex with more than one partner within the past year?
Yes □ No □

_____
Your Signature and Today's Date