



Health History Update

Please Check YES or NO if any of these symptoms are currently present.

Date: _____

NOTE: Please do not leave any blanks

<u>Symptom</u>	<u>Yes</u>	<u>No</u>	<u>Symptom</u>	<u>Yes</u>	<u>No</u>	<u>Symptom</u>	<u>Yes</u>	<u>No</u>
Cardiac:			Respiratory:			Psychiatric:		
Chest Pains			Snoring			Depression		
Palpitations			Hemoptysis (Coughing up blood)			Hallucinations		
Diaphoresis (Excessive sweating)			Dyspnea (shortness of breath)			Hematologic:		
Syncope (fainting)			Gastrointestinal:			Acute Anemia		
Orthopnea (Difficulty breathing laying down)			Nausea			Thrombocytopenia (low blood platelet count)		
PND (breathing disorder related to CHF)			Reflux			Endocrine:		
Vascular:			Bleeding			Goiter (enlarged thyroid)		
Claudication (Pain or limping in legs)			Genitourinary:			Tremors		
Edema or Swelling			Hematuria (Blood in urine)			Derm:		
Constitutional:			Frequent urination at night (>2 times/night)			Rash		
Weight gain			Neurological:			Skin Sores		
Weight loss			Dizziness			Musculoskeletal:		
Fever			Memory loss			Joint Pain		
HEENT: (Head, Ears, Nose & Throat)			Seizures			Myalgia (muscle pain)		
Visual Changes			Reproductive:					
Hearing loss			HX of oral contraception (Birth Control Pills)					

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

(Please see and complete page 2)

Please list any medication changes SINCE YOUR LAST VISIT:

Name:	Dosage/Frequency:	Name:	Dosage/Frequency:
(None)			

Have you been admitted to the hospital SINCE YOUR LAST VISIT?

- No**
- Yes**

- If yes, when:**

- Which hospital?**

- For what reason?**

Pharmacy Information:

Local Pharmacy Name: _____

Address: _____

Phone: _____

Mail-Order Pharmacy Name: _____

Address: _____

Phone: _____

Patient Name: _____ **Date of Birth:** _____