Medical Update Sheet

Name:_____DOB:_____

Please provide any updates to the following *(since your last visit):*

Medical History:

Surgeries or Hospitalizations:

Family History:

Allergies:

Medications:

Please list any recent **labs or x-rays *since your last visit*** and ***where*** you had them performed

Reason for Visit Today:_____

Are you experiencing any of these problems **today?**: ☐ **I am not experiencing any of these**

Eyes
☐Vision Loss
☐Blurred Vision
☐Double Vision

Ears, Nose, Throat
☐Loss of Smell
☐Hearing Loss
☐Hoarseness

Cardiovascular
☐Chest Pain
☐Heart Attack
☐Heart Murmur

Respiratory
☐Wheezing
☐Chronic Cough
☐Short of Breath

Endocrine
☐Excessive Thirst
☐Hot / Cold Intolerance
☐Skin Rash
☐Erectile Dysfunction

Gastrointestinal
☐Nausea / Vomiting
☐Abdominal Pain
☐Constipation
☐Bloody Stools
☐Indigestion
☐Chronic Diarrhea

Constitutional
☐Fever / Chills
☐Weight Loss
☐Fatigue

Neurological
☐Numbness
☐Weakness
☐Tremor
☐Seizure

Hematological
☐Swollen Glands
☐Prolonged Bleeding
☐Bruise Easily

Musculoskeletal
☐Joint Swelling
☐Back Pain
☐Bone Pain
☐Artificial Joint

Gynecological
☐I could be Pregnant
☐Irregular Periods
☐Excessive Cramping
☐Excessive Bleeding
Date of Last Period
_____

Psychiatric
☐Anxiety
☐Depression
☐Psychosis

Genitourinary
☐Urine Retention
☐Painful Urination
☐Urinary Frequency

Office Use Only *HT:_____* *BP:_____* *Pulse:_____*
WT:_____ *Temp:_____*

*Physician Signature*_____ *Date* _____