ANNUAL MEDICAL HISTORY UPDATE

NAME _____ DATE OF BIRTH ___/___/___ AGE ___ TODAY'S DATE ___/___/___

Reason for today's visit: _____

CURRENT MEDICATIONS _____

_____

_____

_____

_____

_____

_____

_____

DRUG ALLERGIES _____ NONE _____

Family history of colon cancer of polyps? _____ ☐ None

Habits: Do you smoke? ☐ Yes ☐ No Alcohol: ☐ None or rare. # of drinks per week:

Past Medical History: Since your last visit - any operations, hospitalizations, or serious illnesses? _____

_____

_____

_____

_____

_____

PLEASE LET US KNOW IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE **LAST 12 MONTHS** OR SINCE YOUR LAST VISIT:

General		
Recent weight or appetite change?	NO	YES
Are you in poor overall health?	NO	YES
Fever	NO	YES
Eyes		
Eye disease	NO	YES
Glaucoma	NO	YES
HENT		
Hearing or ear problems	NO	YES
Headaches	NO	YES
Respiratory		
Chronic or frequent cough	NO	YES
Asthma or wheezing	NO	YES
Difficulty breathing	NO	YES
Any trouble with lungs?	NO	YES
Cardiovascular		
Chest pain or angina pectoris	NO	YES
Heart trouble or heart attacks	NO	YES
High blood pressure	NO	YES
Swelling of hands, feet, or ankles	NO	YES
Heart murmur	NO	YES
Endocrine		
Thyroid problems	NO	YES
Diabetes	NO	YES

Gastroenterology		
Peptic ulcer (stomach or duodenal)	NO	YES
Vomiting blood or food	NO	YES
Gallbladder disease or gallstones	NO	YES
Liver trouble, hepatitis, jaundice	NO	YES
Hemorrhoids, fissures or piles	NO	YES
Recent change in bowel habits	NO	YES
Frequent constipation	NO	YES
Frequent diarrhea	NO	YES
Heartburn or indigestion	NO	YES
Abdominal discomfort or pain	NO	YES
Does food stick in your throat	NO	YES
Rectal bleeding or black stools	NO	YES
Urinary		
Bladder or kidney infections	NO	YES
Kidney stones or blood in urine	NO	YES
Gynecologic		
Endometriosis or ovarian cysts	NO	YES
Date of last menstrual period	___/___/___	
Neuro-Psychiatric		
Do you see a psychiatrist/psychologist?	NO	YES
Are you depressed or "blue"?	NO	YES
Nervous, anxious or panic attacks?	NO	YES
Hematologic		
Blood diseases or anemia	NO	YES
Problems bleeding with surgery?	NO	YES

We want this medical visit to be thorough and up to date! Thank you for your help.

Patient's history (above) reviewed by physician _____ (initial).