Return Patient Medical History Update Form

Date: _____ Account #_____

Name _____

Primary Care Physician_____ (circle if NONE)

Pharmacy preference _____

Reason for visit

_____

_____

Medication Allergies _____

Current Medications, Over the Counter Meds and Supplements:

Please update list that is printed by crossing through any meds you are no longer taking and writing in new meds or if you have a list of medications please attach or ask receptionist to make a copy.

Current Symptoms:

Fever	Y/N
Loss of appetite	Y/N
Weight loss	Y/N
Abdominal pain	Y/N
Change in bowel habits	Y/N
Constipation	Y/N
Diarrhea	Y/N
Heartburn	Y/N
Nausea	Y/N
Rectal bleeding	Y/N
Vomiting	Y/N
Cardiovascular	
Chest pain	Y/N
Shortness of breath	Y/N
Irregular Heartbeat	Y/N
Palpitations	Y/N

ENMT	
Difficulty swallowing	Y/N
Dizziness	Y/N
Ear pain	Y/N
Neurological	
Dizziness	Y/N
Fainting	Y/N
Frequent headaches	Y/N
Seizures	Y/N
Respiratory	
Asthma	Y/N
Cough	Y/N
Shortness of breath	Y/N
Coughing up blood	Y/N