

# Medical History Annual Update

Your name: \_\_\_\_\_

Who is your PRIMARY CARE DOCTOR? \_\_\_\_\_

FIRST NAME

LAST NAME

Do you have now or have you recently had: (please check YES or NO)	Explanation:
1. Recent Fever, Chills, Night sweats	Y <input type="checkbox"/> N <input type="checkbox"/> _____
2. Extreme unplanned Weight Gain/Loss	Y <input type="checkbox"/> N <input type="checkbox"/> _____
3. Ear, Nose, Throat problems: Sinus disease, Vertigo, Dry mouth, Difficulty swallowing	Y <input type="checkbox"/> N <input type="checkbox"/> _____
4. Heart Disease: Angina, Heart attack, High blood pressure, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
5. Lung Disease: Asthma, Emphysema, Shortness of breath, Chronic Obstructive Pulmonary Disease, Congestion, Wheezing, Tuberculosis, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
6. Stomach Disease: Ulcers, Diarrhea, Constipation	Y <input type="checkbox"/> N <input type="checkbox"/> _____
7. Urinary Problems, Prostate problems	Y <input type="checkbox"/> N <input type="checkbox"/> _____
8. Muscle / Joint pain or weakness, Rheumatoid arthritis, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
9. Skin Conditions, Nail or Hair problems, Eczema, Psoriasis, Rosacea, Changing skin spots, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
10. Stroke, Seizures, Memory loss, Weakness, Depression, Anxiety, Hallucinations, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
11. Bleeding Problems, Bruising, Anemia, Sickle cell disease, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
12. Endocrine Problems: Diabetes (indicate how long and what type), Thyroid, Cholesterol, Other	Y <input type="checkbox"/> N <input type="checkbox"/> _____
13. HIV/AIDS	Y <input type="checkbox"/> N <input type="checkbox"/> _____
14. Cancer or tumor (indicate how long and what type)	Y <input type="checkbox"/> N <input type="checkbox"/> _____
15. Other:	Y <input type="checkbox"/> N <input type="checkbox"/> _____

Current Eye Drops/Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Form completed by:  Patient  Family  Staff  Other

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

Reviewed by: \_\_\_\_\_

\_\_\_\_\_  
*Doctor Signature*

\_\_\_\_\_  
*Date*