**Patient Information Update**  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Since your last visit to our office, has your contact information (address, phone number, email, cellphone) changed?

Yes\_\_\_\_: New Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**1) Since your last visit to our office, were you admitted to the hospital?**

Yes ⁪ No ⁪

**If yes, please write where and when**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2) Since your last visit to our office, have you had any medical tests?**

Yes ⁪ No ⁪

If yes, please check any that apply:

⁪ Mammogram (breast xray) ⁪ Pap smear (for women) ⁪ Colonoscopy

⁪ Blood work ⁪ X-rays ⁪ ECG / EKG (heart)

⁪ Vision ⁪ DEXA (checks for bone loss, or osteoporosis)

⁪ MRI ⁪ CT (“CAT” scan) ⁪ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List where and when you had the tests done\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3) Since your last visit to our office, have you developed any new allergies or had a bad reaction to a medication or food?**

Yes ⁪ No ⁪

**If yes, describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4) Since your last visit to our office, have you seen a specialist** (such as a doctor for diabetes, heart, kidneys, cancer, eyes, gynecology, etc.)?

Yes ⁪ No ⁪

**If yes, who did you see and when?**

 Name Approx. Date

 Name Approx. Date

**5) Since your last visit to our office, have you had any vaccinations (shots)?**

Yes ⁪ No ⁪

**If yes, check the shots you received:**

⁪ flu ⁪ tetanus ⁪ pneumonia

⁪ other - please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **6) Since your last visit to our office, have you started any new prescribed medications?**

Yes ⁪ No ⁪

**If yes, list**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7) Since your last visit to our office, have you started any new over-the-counter medications** (such as Advil, Tylenol, aspirin, Tums, etc.), **herbal medications** (such as St. John’s Wort, etc.), **vitamins or minerals** (such as Vitamin C, or Calcium, etc.)?

Yes ⁪ No ⁪

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**8) Has anything changed with the health of your family members (including parents, siblings, or children)?**

Yes ⁪ No ⁪

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9) Do you regularly use:**

**Seat belts** Sometimes ⁪ Always ⁪ N/A ⁪

**Car seats for children in your car** Sometimes ⁪ Always ⁪ N/A ⁪

**10) Do you have a working smoke alarm in your home and have you changed the batteries within the past 6 months?**

Yes ⁪ No ⁪

**11) Do you exercise at least 20-30 minutes 3 times per week?**

Yes ⁪ No ⁪

**12) Do you find it difficult keeping your balance or have you fallen recently?**

Yes ⁪ No ⁪

**13) Do you sometimes have difficulty getting to the restroom “in time,” and/or do you sometimes have urinary accidents when sneezing or coughing?**

Yes ⁪ No ⁪

**14) Do you feel sad, “down,” depressed or hopeless?**

Yes ⁪ No ⁪

**15a) If you smoke or chew tobacco, have you thought about quitting?**

Yes ⁪ No ⁪

**15b) If you’ve thought about quitting, would you like help to do so?**

Yes ⁪ No ⁪

**16) Has anyone been concerned about your drinking of alcohol or use of drugs?**

Yes ⁪ No ⁪

**17) Do you have a gun in the home?**

Yes ⁪ No ⁪

**18) Have you had sex with more than one partner within the past year?**

Yes ⁪ No ⁪

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Signature and Date**