PATIENT HEALTH HISTORY

UPDATE FORM

NAME:_________________________DOB:_________AGE:_____WEIGHT:_______

REASON FOR TODAY'S VISIT:____ ☐R ☐ L

Is this the result of a: ☐Injury ☐ Car Accident ☐ Workplace Injury ☐ Not an Injury

PRIMARY CARE PROVIDER:____

MEDICATION LIST (Include prescriptions, herbals and over the counter medications)

Medication	Strength (dosage)	Times per Day

REVIEW OF SYMPTOMS – Do you have? (Answer yes or no for each)

Fevers, chills	☐ Y ☐ N	Cough	☐ Y ☐ N	Balance issues	☐ Y ☐ N
Night sweats	☐ Y ☐ N	Nausea	☐ Y ☐ N	Leg numbness/tingling	☐ Y ☐ N
Weight loss	☐ Y ☐ N	Vomiting	☐ Y ☐ N	Arm numbness/tingling	☐ Y ☐ N
Headaches	☐ Y ☐ N	Abdominal pain	☐ Y ☐ N	Excessive thirst	☐ Y ☐ N
Dizziness	☐ Y ☐ N	Heartburn/Reflux	☐ Y ☐ N	Anxiety	☐ Y ☐ N
Chest pain	☐ Y ☐ N	Urinary changes	☐ Y ☐ N	Depression	☐ Y ☐ N
Shortness of breath	☐ Y ☐ N	Rash	☐ Y ☐ N	Excessive bruising	☐ Y ☐ N

☐ I have none of the above symptoms.

☐ My primary care physician is aware of my symptoms. **(Please note that if your Primary Care Provider is not aware of the above symptoms, you should notify him/her.)**

List any other changes to your general health, medical history, surgical history, and allergies since your last visit:

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Patient Signature:______________________Guardian (if under 18):_________________________Date:________