Patient Information Update

Name_____
DOB_____

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: _____
_____

_____/_____
Your Signature and Today's Date