Foothill Family Clinic

PATIENT HISTORY UPDATE FORM

Name:_____Birthdate:____ ____ _____ Today's date:____ ____ _____

Please list all **Prescription Medications/Over-the-counter/Vitamins/Supplements** you are currently taking:

Medication Name	Strength	Frequency	Reason for medication	Refill needed?
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N
_____	_____	_____	_____	○Y ○N

List any **Medication Allergies** you may have:

Medication:	Reaction:
_____	_____
_____	_____

SOCIAL HISTORY

Do you use Tobacco? Never Current user Former user Type: Cigarettes Chew Pipe Other:_____
Units/day: .5 1 1.5 2 Other:_____ Years used: _____Years quit:_____
Do you drink Alcohol? No Yes Formerly How many drinks per week? 1-3 4-6 7-10 Other:_____
Do you drink Caffeine? No Yes Type of Caffeine: Soda Coffee Energy drinks Other:_____ Amount/day:_____

PAST MEDICAL HISTORY

Please list any **Recent** Surgeries or Hospitalizations you have had **SINCE YOUR LAST PHYSICAL:**

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____

Please list and **New** Medical Conditions or Injuries **SINCE YOUR LAST PHYSICAL**:

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Please list any **Recent** Family History **SINCE YOUR LAST PHYSICAL:**

		Which Family Members?			**Which Family Members?**
Alzheimer's Disease	○Y ○N	_____	High Cholesterol	○Y ○N	_____
Asthma	○Y ○N	_____	High Blood Pressure	○Y ○N	_____
Blood Disease	○Y ○N	_____	Mental Illness	○Y ○N	_____
Depression	○Y ○N	_____	Migraines	○Y ○N	_____
Cancer	○Y ○N	_____	Osteoarthritis	○Y ○N	_____
CVA(stroke)	○Y ○N	_____	Osteoporosis	○Y ○N	_____
Diabetes	○Y ○N	_____	Heart Disease	○Y ○N	_____
Heart Disease	○Y ○N	_____	Other:_____	○Y ○N	_____

Continued on back side →

REVIEW OF SYSTEMS

Circle any item that relates to your current state of health: **(Leaving an item unmarked indicates a NEGATIVE response)**

GENERAL HEALTH
Chills
Fatigue
Fever
Malaise
Night Sweats
Weight Gain
Weight Loss
Other:
Exercise Intolerance
Change in Appetite
Irritability

HEENT
Ear Drainage
Ear Pain
Eye Discharge
Eye Pain
Hearing Loss
Nasal Drainage
Sinus Pressure
Sore Throat
Visual Changes
Other:
Difficulty Swallowing
Double Vision
Jaw Pain
Mouth Ulcers
Ringing in Ears
Sensitivity to Light
Snoring
Tooth Pain

RESPIRATORY
Chronic cough
Cough
Known TB exposure
Shortness of breath
Wheezing
Other:
Apnea
Asthma
Coughing Blood
Painful Respirations
Respiratory Infections
Trouble Breathing

CARDIOVASCULAR
Chest Pain
Leg Pain w/ Walking
Edema
Palpitations
Other:
Irregular Heart Beat
Loss of Consciousness
Tingling in Extremity

GASTROINTESTINAL
Abdominal Pain
Blood in Stools
Change in Stool
Constipation
Diarrhea
Heartburn
Loss of Appetite
Nausea
Vomiting
Other:
Acid Reflux
Fecal Incontinence
Hemorrhoids
Rectal Bleeding

GENITOURINARY
Dribbling
Painful Urination
Blood in Urine
Excessive Urination
Slow Stream
Urinary Frequency
Urinary Incontinence
Urinary Retention
Other:
Flank Pain
Foul Urine Odor
Kidney Stones
Recurrent UTI

REPRODUCTIVE (Females only
Abnormal pap
Breast discharge
Breast lump
Painful menstruation
Painful intercourse
Hot flashes
Irregular menses
Vaginal discharge
Other:
Fibroids
Genital lesions
Infertility
Ovarian cysts
Vaginal dryness
Vaginal itching

REPRODUCTIVE (MALES ONLY)
Erectile Dysfunction
Penile Discharge
Sexual Dysfunction
Other:
Circumcised
Genital Lesions
Blood in Semen
Infertility
Painful Ejaculation
Testicular Mass
Testicular Pain

METABOLIC/ ENDOCRINE
Cold Intolerance
Heat Intolerance
Excessive Thirst
Excessive Hunger
Other:
Excessive Perspiration
Growth Delay

NEUROLOGICAL
Dizziness
Extremity Numbness
Extremity Weakness
Gait Disturbance
Headache
Memory Loss
Seizures
Tremors
Other:
Altered Mental Status
Confusion/Disorientation
Facial Droop
Focal Weakness
Frequent Falls
Speech Changes
Trouble Speaking

PSYCHIATRIC
Anxiety
Depression
Insomnia
Other:
Behavior Changes
Difficulty Concentrating
Difficulty Sleeping
Excessive Stress
Problems Coping
Suicidal Thoughts

INTEGUMENTARY
Brittle Hair
Brittle Nails
Hair Loss
Hives
Itching
Mole Changes
Rash
Skin Lesion
Other:
Acne
Eczema
Skin Infection

MUSCULOSKELETAL
Back Pain
Joint Pain
Joint Swelling
Muscle Weakness
Neck Pain
Other:
Arthritis
Osteoporosis

HEMATOLOGIC/ LYMPHATIC
Easy Bleeding
Easy Bruising
Swollen Lymph Nodes

IMMUNOLOGIC
Contact Allergy
Environmental Allergies
Food Allergies
Seasonal Allergies