History Update Form

Date:_____

East Springdale Family Clinic
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Patient's Name: _____Date of Birth:_____

Age Sex: ☐Male ☐Female

Briefly describe what problem(s) brings you to the doctor: _____
_____
_____

In order to keep your chart updated with your most current health history, please answer the following questions. If you have not had any changes to this area of your health history since your last visit to the clinic, please check no. If you have had any changes, please mark yes and tell us what has changed in the space provided below.

1. Have you started any new medications?	☐ Yes	☐ No
2. Have you had any new reactions to medications or foods?	☐ Yes	☐ No
3. Have you had any new immunizations/shots?	☐ Yes	☐ No
4. Have you been diagnosed or treated for any new medical problems?	☐ Yes	☐ No
5. Have you been treated by a specialist physician?	☐ Yes	☐ No
6. Have you been hospitalized or treated in the ER?	☐ Yes	☐ No
7. Have you had any new Surgeries or other procedures?	☐ Yes	☐ No
8. Have you had any new testing such as labs, x-rays, or stress tests?	☐ Yes	☐ No
9. Have you changed any habits such as smoking or exercise?	☐ Yes	☐ No
10. Have there been any new medical problems diagnosed in your family?	☐ Yes	☐ No

_____

_____

_____

_____

_____

Social History:
☐Single ☐Married ☐Divorced ☐Widowed
Occupation:_____
Religion:_____

Do you use or have you ever used tobacco?
☐ No ☐ Yes, how much_____
If quit, when?_____

Please see the other side ⟶

REVIEW OF SYSTEMS:

DOYOU NOW OR HAVE YOU RECENTLY HAD PROBLEMS WITH ANY OF THE FOLLOWING?
(PLEASE CIRCLE YOUR ANSWERS)

GENERAL	Change in weight	Fever			
GENITAL/URINARY SYSTEM	Pain or burning with urination	Kidney stone	Frequency	Slow or small stream	Blood in urine
	Getting up at night to urinate	Leaking of urine	urgency	Poor bladder emptying	Recurrent urine infections
	Abnormal vaginal bleeding	Menstrual problems	Sexual problems		
SKIN	Lumps or nodules	Breast lump	rashes	sores	Other skin problems
EYES	glaucoma	cataracts	glasses	Other eye problems	
EARS, NOSE & THROAT	Trouble swallowing	Nose bleeds	dentures	Sinus problems	Earaches
BLOOD/LYMPH	Swollen nodes or glands	Bleeding problems	anemia	Other blood disorders	
HEART & VASCULAR	Irregular heart beat	Heart failure	angina	Heart valve problems	Heart murmur
	Pain in legs with exertion	Chest pain	phlebitis	Swelling in legs	Blood clots
	Other heart/blood vessel problems				
RESPIRATORY	Shortness of breath	wheezing	cough	asthma	Other lung problems
GASTROINTESTINAL	Gallbladder problems	Blood in stool	diarrhea	Dark tarry stools	Intestinal bleeding
	Poor appetite	Hiatal hernia	ulcer	indigestion	Hemorrhoids
	constipation	vomiting	nausea	hernia	
NEUROLOGICAL	Loss of consciousness	headaches	strokes	dizziness	paralysis
	numbness	Weakness			
PSYCHOLIGICAL	Other psychological problems	depression	Anxiety		
MUSCULOSKELETAL	Joint replacement surgery	Broken bones	gout	arthritis	Bone or joint pain
ENDOCRINE	Heat or cold intolerance	Hot flashes	flushing	Abnormally thirsty	Skin pigmentation change