

Health History / Yearly Exam Update

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

What is the reason for your appointment today? (please mark all that apply)

- physical exam     physical exam with pap smear
- Follow up for  diabetes     high blood pressure     high cholesterol / triglycerides     depression/anxiety
- asthma     joint aches     hypothyroidism     osteopenia / osteoporosis
- GERD     hayfever/sinus problems     other \_\_\_\_\_
- new problem (please explain) \_\_\_\_\_

● Since your last physical exam have you had any new diagnosed medical problems?    yes    no  
 If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_

● Since your last physical exam have you had any surgeries?    yes    no  
 If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_

● Since your last physical exam have you had any allergic reaction to medications?    yes    no  
 If yes, please list the medication and the reaction \_\_\_\_\_

● Do you smoke?    yes    no    If yes, how much? \_\_\_\_\_

● Do you drink alcohol on a regular basis?    yes    no    If yes, how much? \_\_\_\_\_

● Do you have any close relatives with the following conditions?    yes    no  
 Circle any that apply and explain below, please list any additional.

Breast cancer                      colon cancer                      diabetes                      heart disease

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● Do you exercise on a regular basis?    yes    no  
 If yes, what kind of exercise? \_\_\_\_\_ How often? \_\_\_\_\_ times per week  
 How long? \_\_\_\_\_ minutes/time

● Do you follow a specific diet?    yes    no  
 If yes, what kind? \_\_\_\_\_

● Have you received any immunizations since your last visit?    yes    no  
 tetanus    pneumovax    zostavax    varicella    flu shot    other \_\_\_\_\_

● Please mark if you have had any of the following recently and explain below:     **None**

- Chest pain                       Incontinence                       Abdominal pain                       depression                       Fever
- Palpitations/  
Heart fluttering                       Urinary  
frequency                       Blood in stool                       problems  
sleeping                       Weight loss  
 Weight gain
- Cough                       Urinary burning                       Diarrhea                       anxiety                       Muscle aches
- Shortness of  
Breath                       Blood in urine                       Constipation                       suicidal  
thoughts                       New or growing  
moles
- Frequent  
heartburn  
> twice a week

If this is your yearly exam:  Not Applicable

Females

- Hysterectomy  Postmenopausal (Any postmenopausal bleeding? yes no )
- First day of your last menstrual period? \_\_\_\_\_
- What type of birth control do you use? \_\_\_\_\_
- Are your periods regular? \_\_\_\_\_ Are they heavy? \_\_\_\_\_
- Are you sexually active? Yes No Any problems with intercourse? \_\_\_\_\_

Males

- Any problem with sexual function? yes no
- Any testicular lumps? yes no
- Any penile discharge? yes no

If you are diabetic:  Not Applicable

- How often do you check your sugars? \_\_\_\_\_
- What have your sugars been recently? Highest \_\_\_\_\_ Lowest \_\_\_\_\_ Average \_\_\_\_\_
- When was your last eye exam? \_\_\_\_\_ Do you any diabetic eye disease ? yes no
- Do you follow a diabetic diet? \_\_\_\_\_
- Do you look at your feet everyday? yes no Any problems? \_\_\_\_\_
- Have you seen the diabetes educator? yes no When was the last time? \_\_\_\_\_

If you have hypertension:  Not Applicable

- Do you check your blood pressure at home or elsewhere? yes no  
If yes, how often? \_\_\_\_\_  
Please list your recent readings \_\_\_\_\_

If you have high cholesterol / triglycerides:  Not Applicable

- Have you been following a low cholesterol diet? yes no
- If you are on cholesterol medication, have you had any unusual body aches or weakness? yes no

● Please list all of your current prescription medications including strength and dosage.  no medications

Medication	Dosage	Frequency	Prescribed By (if another M.D.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Use back of page for additional Medications