Existing Patient Health Update Form

Date:

Name:	DOB:	Age:

If there have been any changes to your contact Information, please update:

Address:	
Home Phone:	
Cell Phone:	
Email Address:	

If there have been any changes to your insurance information, please update:

Primary Insurance:	Group#:
Subscriber:	Policy#:
Subscriber SS# (req.):	Subscriber DOB:

Current Medical History

First Day of Last Period:

Please list any new medical problems or issues you want to discuss with the doctor:

Please list all medications you are currently taking:

Please circle any current symptoms you are experiencing:

General	Weight Loss Weight Gain Fever Fatigue
Head & Eyes	Headache Vision Change Dry Eyes
Ear, Nose, Throat	Sore Throat Sinus Problems Hearing Loss Ear Pain
Cardiovascular	Chest Pain Palpitations Irregular Heart Beat Leg Swelling
Respiratory	Shortness of Breath Wheezing Cough
Gastrointestinal	Constipation Diarrhea Vomiting Indigestion Bloody Stool Fecal/Gas Incontinence Abdominal Pain Food Intolerance
Urinary	Painful Urination Urgency Frequency Incontinence Bloody Urine
Gyncologic	Abnormal Periods Pain with Intercourse Abnormal Discharge Pelvic Pain PMS Abnormal Vaginal Bleeding
Musculoskeletal	Muscle Weakness Muscle Pain Joint Pain Joint Swelling
Skin	Dryness Rash Moles Sores
Breast	Pain Discharge Lump/Mass
Endocrine	Hot flashes Heat/Cold intolerance Thyroid problem Hair Loss
Psychiatric	Depression Anxiety
Neurologic	Numbness Tingling Fainting Seizures Dizziness
Hematologic	Easy Bruising Prolonged Bleeding Enlarged Glands

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