IVCH Medical Group

Medical History Update

Patient Name: **DOB:**

Since your last appointment has your medications changed?

☐ **No new Medications** **List all medications you take, both perscription & nonprescription below:**

Are you taking Aspirin or anyother blood thinners? ☐Yes ☐ No ** If YES why do you take:

Medication/ Supplement, Dose	How often Taken (ex Daily)	Why are you taking (ex High BP, Thyroid, etc)	Medication/ Supplement, Dose	How often Taken (ex Daily)	Why are you taking (ex High BP, Thyroid, etc)

YOUR VACCINATIONS	
Did you have a flu shot? ☐Yes ☐No	If yes date received: From:
Did you have a Pnemonia shot? Yes ☐ No ☐	If yes date received: From:

Since your last appointment have you been diagnosed with any of the following?

☐ **No Relevant Medical History since my last appointment**

Disease Type	Date of Onset	Disease type	Date of Onset
Hypertension ☐ Yes ☐ No		Obesity ☐ Yes ☐ No	
Kidney Disease ☐ Yes ☐ No		Osteoarthritis ☐ Yes ☐ No	
Heart Disease ☐ Yes ☐ No		Anxiety ☐ Yes ☐ No	
Diabetes I or II ☐ Yes ☐ No		Depression ☐ Yes ☐ No	
Peripheral Vascular Disease ☐ Yes ☐ No		Bipolar Depression ☐ Yes ☐ No	
Pulmonary Embolism ☐ Yes ☐ No		Lung Disease-Type: ☐ Yes ☐ No	
DVT/Blood clots-Leg or Lung ☐ Yes ☐ No		Ulcers ☐ Yes ☐ No	
Cancer-Type: ☐ Yes ☐ No		GERD ☐ Yes ☐ No	
Stents in Heart or Leg ☐ Yes ☐ No		Osteoporosis ☐ Yes ☐ No	
Sleep Apnea: USES CPAP ☐ Yes		HIV/AIDS ☐ Yes ☐ No	
Atrial Fibrillation ☐ Yes ☐ No		Hepatitis(A, B or C) ☐ Yes ☐ No	
Stroke ☐ Yes ☐ No		Fracture: ☐ Yes ☐ No	
Dementia/Forgetfulness ☐ Yes ☐ No		Back Problem-Type: ☐ Yes ☐ No	
Are you taking Aricept or Numenda? ☐Yes ☐ No		Anemia ☐ Yes ☐ No	
☐ Other:		☐ Other:	

OVER→

Since your last update have you had any of the following?

YOUR OTHER MEDICAL HISTORY AND SCREENINGS	
Do you have any of the following:	
Coronary Artery Disease: ☐ No ☐ Yes	Who treats you:
Heart Failure: ☐ No ☐ Yes	Who treats you:
Ischemic Vein Disease: ☐ No ☐ Yes	Who treats you:
Have you had any of the following screenings with your PCP:	
Mammogram: ☐ No ☐ Yes, if yes Date:_____	Colorectal Screening: ☐ No ☐ Yes, if yes Date:
If you are Diabetic have you had the following this year:	
Yearly A1C blood test: ☐ No ☐ Yes if yes when: With	**Yearly Eye exam:** ☐ No ☐ Yes if yes when: With

Since your last update did you have any new allergies?

☐ **No new Allergies** — **YOUR ALLERGIES**

Indicate all allergies you have to medications and/or food & describe reation below: Common reactions include-Anaphylaxis(life Threatening), Hives, Itching, Nausea/Vomiting, Trouble breathing ☐ **Latex** ☐ **Adhesive Tape**

Allergic to	Reaction	Allergic to:	Reaction

Since your last update do have any changes to your Surgical History?

☐ **No new Surgeries** — **YOUR SURGICAL HISTORY**

Surgery Type: Provider who preformed	Year of Surgery	Surgery Type: Provider who preformed	Year of Surgery

Since you last update did you have any changes to your Family History?

☐ **No Change** — **YOUR FAMILY HISTORY**

Mother	Father	Sister	Brother
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Cancer-Type:	☐ Cancer-Type:	☐ Cancer-Type:	☐ Cancer-Type:
☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung	☐ Blood Clot-Leg or lung
☐ Respirtory issues	☐ Respirtory issues	☐ Respirtory issues	☐ Respirtory issues
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Since you last update did you have any changes to your Social History?

☐ **No Change** — **YOUR SOCIAL HISTORY**

Tobacco Use: ☐ Current ☐ Former ☐ Never Type:_____ Packs/Day:_____ Years Used: _____ Have you ever tried to quit? ☐ Yes ☐ No	**Alcohol Use:** ☐ Yes ☐ No ☐ Former Type: (circle): Beer Wine Liquor Frequency:_____	**Caffeine Use:** ☐ Yes ☐ No Type:_____ Daily Amount:_____

YOUR ATTESTATION	
I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan	
Patient Signature:	**Date:**
If Minor, Guardian Signature:	**Date:**

Patient Name: **DOB:**

Review of Systems: **Are you currently experiencing any of the following?**
(Please check all that apply for the following)

Musculoskeletal

☐ Joint Pains ☐ Elbow Pain
☐ Joint Swelling ☐ Wrist Pain
☐ Joint Stiffness ☐ Hand Pain
☐ Unsteady gait ☐ Hip Pain
☐ Neck pain ☐ Back Pain
☐ Shoulder Pain ☐ Knee Pain
☐ Ankle Pain ☐ Foot Pain
☐ Other:

Neurological

☐Numbness ☐ Weakness
☐ Tingling
☐ Dizziness
☐ Headaches
☐ Tremors
☐ Seizures
☐ Other:

Integumentary

☐ Poor Healing wounds
☐ Redness
☐ Rash
☐ itching
☐ Scarring/Keloids
☐ Bruising
☐ Other:

Constitutional/Symptoms

☐ Fatigue
☐ Unexpected weight loss
☐ Fever
☐ Chills
☐ Weight gain
☐ Other:

Hematologic/Lymphatic

☐ Easy Bleeding
☐ Easy Bruising
☐ Enlarged Lymph nodes
☐ Other:

Allergic/Immunologic

☐ Immunosuppression
☐ Allergic reaction to foods/ environment
☐ Other:

Cardiovascular

☐ Chest Pain
☐ Palpitations
☐ Fainting
☐ Shortness of Breath
☐ Irregular Heartbeat
☐ Heart murmur
☐ Leg Cramps
☐ High blood pressure (even if controlled with medication)
☐ Other:

Endocrine

☐ Excessive thirst or urination
☐ Heat/Cold intolerance
☐ Diabetic

ENT & Mouth

☐ Nose bleeds
☐ ringing in ears
☐ Hoarseness
☐ Hearing Aids
☐ Dentures or Bridge
☐ Other:

Eyes

☐ Corrective Lenses/Glasses
☐ Blurred vision
☐ Other:

Gastrointestinal/GI

☐ Heartburn
☐ Nausea/vomiting
☐ Constipation
☐ Diarrhea
☐ Bloody/tarry stools
☐ Other:

Genitourinary/GU

☐ frequent urination
☐ Incontinence
☐ Blood in urine
☐ Other:

Respiratory

☐ Shortness of breath
☐ Wheezing
☐ Cough
☐ Hurts to breath
☐ Other:

Psychiatric

☐ Nervousness
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Dementia/Forgetfulness