

Established Patient Health History Update

Patient Last Name: _____ First Name: _____ DOB: _____

Last Menstrual cycle: _____ Chief Complaint/Reason for today's visit: _____

Please List any Physicians you would like to receive a report of today's visit: _____

Past Medical History

Since your last visit to Dr Hobson, are you being treated for any new symptoms or diagnosis? Yes / No

If yes, please list: _____

Have you had any surgeries, procedures, or hospitalizations since your last visit? Yes / No

If yes, please list (include) location and dates: _____

Medication History

Have you acquired any new allergies since your last visit? Yes / No

If yes, please list: _____

Please list your medications (prescription and over the counter) with doses and frequency: _____

Review of Systems

Have any family members been diagnosed with a significant medical problem? Yes / No

Please Elaborate: _____

Have there been any changes in you employment or home life? Yes / No

Please Elaborate: _____

Since Your Last Visit, Have You Had Any Of The Following?

Constitutional Circle One
 Weight loss Yes No
 Weight gain Yes No
 Fever Yes No
 Fatigue Yes No

Cardiovascular Circle One:
 Chest Pain Yes No
 Difficult breathing Yes No
 Swelling of legs Yes No
 Palpitation of heart Yes No
 High blood Pressure Yes No

Respiratory Circle One
 Shortness of breath Yes No
 Chronic cough more Than 3 weeks Yes No

Hematologic/skin Circle One
 Frequent bruises Yes No
 Swollen glands Yes No

Genitourinary Circle One
 Blood in urine Yes No
 Pain with urination Yes No
 Abnormal discharge Yes No
 Abnormal bleeding Yes No
 Painful intercourse Yes No
 Painful Intercourse Yes No
 PMS Yes No
 Painful periods Yes No
 Problems getting pregnant Yes No

Musculoskeletal Circle One
 Muscle weakness Yes No
 Joint, neck, or back pain Yes No

Gastrointestinal Circle One
 Frequent diarrhea Yes No
 Blood in stool Yes No
 Abdominal pain Yes No
 Indigestion/heartburn Yes No
 Nausea/Vomiting Yes No
 Constipation Yes No

Endocrine Circle One
 Dry Skin Yes No
 Abnormal thirst Yes No
 Hot flashes Yes No
 Too hot/cold Yes No
 Tired/sluggish Yes No

Neurological Circle One
 Numbness/tingling Yes No
 Trouble walking Yes No

Psychiatric Circle One
 Are you generally satisfied with your life? Yes No
 Depression Yes No
 Frequent crying Yes No
 Do you hear voices Yes No
 Have you considered suicide Yes No

Patient note section *Please elaborate on any of the above as needed:*

Patient's Signature _____ Date _____

Providers Signature _____ Date _____

