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PATIENT HISTORY UPDATE

NAME_____ DATE_____

PRIMARY CARE PHYSICIAN_____

SMOKING STATUS: CURRENT _____ PER DAY FORMER _____YEAR QUIT NEVER

ALCOHOL STATUS: REGULAR_____/ DAY OCCASIONAL_____/WEEK RARE_____ /MONTH NEVER

HAVE YOU **EXPERIENCED** OR **BEEN TREATED** FOR ANY OF THE FOLLOWING SINCE YOUR LAST VISIT

SYMPTOM	SINCE LAST VISIT		PLEASE EXPLAIN
EYE PROBLEMS	NEW	NONE	_____
EAR PROBLEMS	NEW	NONE	_____
NOSE PROBLEMS	NEW	NONE	_____
LUNG PROBLEMS	NEW	NONE	_____
HEART PROBLEMS	NEW	NONE	_____
URINARY / KIDNEY PROBLEMS	NEW	NONE	_____
DIGESTIVE / LIVER PROBLEMS	NEW	NONE	_____
MALE OR FEMALE ORGANS	NEW	NONE	_____
BONE PROBLEMS	NEW	NONE	_____
SKIN PROBLEMS	NEW	NONE	_____

PLEASE CIRCLE THE APPROPRIATE RESPONSE AND EXPLAIN IN THE SPACE PROVIDED. IF YOU DO NOT HAVE THE SYMPTOM, PLEASE CIRCLE "N/A."

FAINTING	MORE	LESS	SAME	N/A	_____ ____
DIZZINESS	MORE	LESS	SAME	N/A	_____ ____
LIGHTHEADEDNESS	MORE	LESS	SAME	N/A	_____
MEMORY LOSS	MORE	LESS	SAME	N/A	_____
TREMORS / SHAKING	MORE	LESS	SAME	N/A	_____
SEIZURES	MORE	LESS	SAME	N/A	_____
NUMBNESS / TINGLING	MORE	LESS	SAME	N/A	_____
NECK PAIN	MORE	LESS	SAME	N/A	_____
BACK PAIN	MORE	LESS	SAME	N/A	_____
DIFFICULTY WALKING	MORE	LESS	SAME	N/A	_____
DIFFICULTY WITH BALANCE	MORE	LESS	SAME	N/A	_____
DIFFICULTY WITH SPEECH	MORE	LESS	SAME	N/A	_____
HEADACHE	MORE	LESS	SAME	N/A	_____
INCONTINENCE	MORE	LESS	SAME	N/A	_____

HAVE YOU HAD ANY SURGERIES SINCE YOUR LAST APPOINTMENT?

YES NO _____

HAVE YOU BEEN DIAGNOSED OR RECEIVED TREATMENT FOR ANY OF THE FOLLOWING?

BLOOD PRESSURE PROBLEMS	YES	NO	_____
DIABETES	YES	NO	_____
CHOLESTEROL PROBLEMS	YES	NO	_____
HEART DISEASE	YES	NO	_____
THYROID PROBLEMS	YES	NO	_____