

Medical History Update
(to be filled out at the time of yearly physical)



Name: _____

Date of Birth: _____

Since your last physical, please list any new health problems, or health concerns:

Since your last physical, please list any hospitalizations or surgeries you've had, and the approximate dates:

Please list all of your **current medications**, including dosage. Also include any over-the-counter medications or vitamins:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any new medication allergies, and the type of reaction:

Marital Status:

Single Married Divorced Separated Widowed Live w/Significant Other

How many people, including yourself, live in your household? _____

What is the relationship of the other people in your household (for example: spouse, son, mother, cousin, friend, roommate, etc.)?

Employment Status (circle one):

Full-time Part-time Unemployed Retired Disabled Homemaker Student

If employed, please list name of employer and job title:

Personal Habits:

Do you currently use tobacco? _____.

If yes, what kind: Cigarettes Chew Snuff Cigars

If you smoke, how many packs per day and for how many years? _____

Do you drink alcohol? _____.

If yes, approximately how many drinks per week:

0-1 2-4 5-7 8-10 11-14 14-20 >20

Do you currently use any illegal drugs (this information is kept confidential)? _____

If yes, please list what kind of illegal drugs and how often you use them (daily, weekly, monthly, etc): _____

Are you currently following any special diet (for example: vegetarian, low cholesterol, low salt, etc)?

Do you currently exercise? _____

If yes, list what kind of exercise and how often:

Family History: Please list any changes in family medical history, if applicable

Mother: Alive Deceased List current age, or the age she died: _____

New medical problems, if any:

Father: Alive Deceased List current age, or the age he died: _____

New medical problems, if any:

Brothers:

How many? _____ List current ages if applicable: _____

New medical problems, if any:

Sisters:

How many? _____ List current ages if applicable: _____

New medical problems, if any:
