The Oaks
Family Healthcare LLC

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Medical History Update Form

Today's Date: _____

Please complete the below information, to the best of your knowledge.

Medical History

PLEASE CIRCLE ANY ILLNESSES YOU HAVE HAD:

Anxiety	Thyroid Disease	COPD	Osteoporosis
Asthma	Gout	Kidney Disease	Lupus
Blood Clots	Heart Disease	Kidney Stones	Rheumatoid Arthritis
High Cholesterol	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis	Lung Disease	Sexually Transmitted Infection
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble
Stroke	Fibromyalgia	A-Fib	IBS/Inflammatory Bowel Disease
BPH	Sleep Apnea	Neurological Disease	Anemia

DIABETES (**last A1C** & **TYPE**) :

CANCER (if yes, location, type, date of diagnosis, treatment) :

Psychiatric Disorders (if yes, current treatment and treating doctor) :

Other Medical Conditions not listed above:

PREVIOUS SURGERIES/INJURIES IN THE LAST YEAR (and date):

DRUG ALLERGIES (also list reactions): ☐ None

SOCIAL HISTORY: Single, Married, Divorced, Widowed, Living with:

Smoking: ☐ No ☐ Yes, Packs a day _____, How long _____ Circle Type: (pipe, cigar, cigarettes, vape, chew)
Recently quit _____, Wants to quit _____

Alcohol: ☐ No ☐ Yes, Drinks/day average _____ Circle Type: (beer, wine, liquor)

Substance Abuse: ☐ Y or ☐ N; List type of drug(s) used: _____

Caffeine: ☐ Y or ☐ N Drinks/day average _____ Circle Type: (tea, coffee, sodas, medicine, foods)

HOSPITALIZATIONS THIS YEAR (list reason/date):

MEDICATIONS: See Below List Attached

NAME/DOSE/HOW IT'S TAKEN	NAME/DOSE/HOW IT'S TAKEN
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

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Reason for Visit: _____

Check any associated symptoms below

CONSTITUTIONAL: ☐ fevers/chills ☐ night-sweats ☐ anorexia ☐ weight loss ☐ weakness ☐ body aches ☐ sleep disorder ☐ weight gain

EYES: ☐ blurry vision ☐ double vision ☐ discharge ☐ eye pain ☐ light sensitivity ☐ eye irritation

EARS, NOSE, MOUTH & THROAT: ☐ decreased hearing ☐ runny nose ☐ mouth sores ☐ sore throat ☐ sinus ☐ congestion ☐ ringing in the ears ☐ nosebleeds ☐ difficulty swallowing ☐ hoarseness ☐ earache

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ decreased exercise tolerance ☐ lightheadedness ☐ shortness of breath ☐ swelling of hands or feet ☐ difficulty breathing while ☐ lying down ☐ fainting ☐ leg cramps with activity ☐ racing heart ☐ near fainting

RESPIRATORY: ☐ cough ☐ shortness of breath ☐ coughing up blood ☐ wheezing ☐ excessive ☐ sputum ☐ excessive snoring ☐ sleep disturbances due to breathing

GASTROINTESTINAL: ☐ nausea/vomiting ☐ difficulty swallowing ☐ heartburn ☐ diarrhea ☐ blood in stools ☐ abdominal pain ☐ regurgitation ☐ bloating ☐ constipation ☐ significant ☐

GENITOURINARY: ☐ pain/burning with urination ☐ blood in urine ☐ frequency ☐ urgency ☐ unable to empty bladder ☐ trouble starting urinary stream ☐ nighttime urination ☐ foul urine odor ☐ kidney pain ☐ inability to control bladder ☐ genital sores ☐ lack of sexual drive ☐ missed period ☐ abnormal vaginal bleeding

MUSCULOSKELETAL: ☐ joint pain/swelling ☐ weakness ☐ stiffness ☐ arthritis ☐ gout ☐ loss of strength ☐ fluid in joint

DERMATOLOGIC: ☐ rashes ☐ suspicious skin lesions

NEUROLOGICAL: ☐ headaches ☐ poor balance ☐ numbness ☐ difficulty with coordination ☐ falling ☐ sensation of room spinning ☐ tremors ☐ memory loss ☐ excessive daytime ☐ ☐ ☐

PSYCHIATRIC: ☐ anxiety ☐ depression ☐ thoughts of suicide ☐ thoughts of violence ☐ frightening visions or sounds ☐ sense of great danger ☐ other mental problems

ENDOCRINOLOGY: ☐ cold intolerance heat intolerance ☐ excessive urination ☐ excessive thirst ☐ significant weight change

HEMATOLOGY: ☐ enlarged lymph nodes ☐ excessive bleeding ☐ abnormal bruising ☐ fevers