

Established Patient Medical Update

Date: ____/____/____

Phone: (____) _____

Cell Phone: (____) _____

Patient Name: _____

DOB: ____/____/____

Sex: M F

Ref / PC Physician: _____ Pharmacy: _____ Phone: _____

Allergies: _____

Please answer the following questions about your personal ***past*** medical history:

Cardio-vascular:

- Heart attack
- Heart murmur
- High blood pressure
- Deep Vein Thrombosis
- Heart valve problems
- Anemia
- Irregular heart beat
- Bleeding tendency
- Coronary artery disease
- Congestive heart failure

Endocrine:

- Insulin dependent
- Diabetes/diet
- HYPERthyroid
- HYPOthyroid
- Gout disease

GI:

- Acid reflux
- Irritable bowels
- Peptic Ulcers
- Diverticulitis
- Constipation/diarrhea

GU:

- Kidney stones
- Bloody urine
- Bladder stones
- Erectile dysfunction
- Frequent UTI's
- Elevated PSA
- BPH
- Incontinence
- Prostatitis
- Overactive bladder

HEENT:

- Glaucoma
- Cataracts
- Hayfever
- Vertigo
- Ear Infection

Musculo-skeletal:

- Arthritis
- Low Back Pain
- Fibromyalgia
- Joint replaced: _____

Neurologic:

- Stroke
- Seizures
- Migraines
- Polio
- Parkinson's
- Spinal cord injury
- Chronic headaches
- Spina bifida
- Multiple Sclerosis
- Unsteady gait

Pulmonary:

- Emphysema
- Asthma
- Bronchitis
- COPD
- Lung Cancer

Hematology/Oncology:

- Prostate cancer
- Uterine cancer
- Bladder cancer
- Lymphoma
- Kidney cancer
- Leukemia
- Testicle cancer
- Ovarian cancer
- Colorectal cancer
- Other: _____

PAST SURGERIES:

- Heart Surgery
- Hysterectomy
- Gall Bladder
- Thyroid
- Colon Resection
- Hip / Knee / Back
- Hernia
- Lung
- Kidney Stones
- Basal Cell Carcinoma
- Nephrectomy
- Squamous Cell Carcinoma
- Other: _____

FAMILY MEDICAL HISTORY:

Father or Mother families or Sibling having any of the following?

- | | | |
|--------------------------|-----|-------------------------|
| Prostate Cancer | Y N | Father, Mother, Sibling |
| Kidney Cancer | Y N | Father, Mother, Sibling |
| Bladder Cancer | Y N | Father, Mother, Sibling |
| Colon Cancer | Y N | Father, Mother, Sibling |
| Bleeding Disorder | Y N | Father, Mother, Sibling |
| Polycystic Kidneys | Y N | Father, Mother, Sibling |
| Kidney Failure | Y N | Father, Mother, Sibling |
| Kidney or Bladder Stones | Y N | Father, Mother, Sibling |
| Urinary Tract Infections | Y N | Father, Mother, Sibling |
| Interstitial Cystitis | Y N | Father, Mother, Sibling |

MEDICATIONS (LIST NAME & DOSAGE):

I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by my physician for processing of my medical claim.

Signature of

Patient / Insured / Legal Guardian: _____

Date: _____