PATIENT HISTORY UPDATE

Name:_____

Address:_____

Preferred Phone Number:_____ **DOB:**_____

Marital Status: single married divorced widowed

Primary Care Physician – Name and Phone Number:

_____

Pharmacy Name & Phone Number:_____

Allergies to Medications:_____

Current Medications:_____

_____

Herbal Supplements:_____

Illness/Hospitalization/Surgery (since last visit):_____

_____

Total Pregnancies:____ **Total Deliveries:**____ **Living Children:**____

Miscarriages:____ **Terminations:**____

Tobacco Use/Amount:_____

Alcohol Use/Amount:_____

Substance Use:_____

First Day of Last Period:_____

Contraceptive Method:_____

Most Recent Mammogram:_____ **Bone Density Study:**_____

Colonoscopy:_____ **Colposcopy (for abnormal pap):**_____

Any Additional Information:_____

_____

Permission to leave medical information on voicemail (please circle): Home Cell Business

THE INFORMATION LISTED ABOVE IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature:_____ **Date:**_____