



HISTORY UPDATE

NAME: _____

DATE: _____

Thank you for taking the time to answer these questions.

Please check any symptoms which you are currently experiencing.

General		Gastrointestinal		Head/Ears/Nose/Throat	
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	Headache
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>		<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Congestion
Skin/Hair		Breast		Neurologic	
<input type="checkbox"/>	Rash	<input type="checkbox"/>	Breast lumps	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Skin lesions	<input type="checkbox"/>	Breast Tenderness	<input type="checkbox"/>	Tingling
<input type="checkbox"/>		<input type="checkbox"/>	Nipple Discharge	<input type="checkbox"/>	Numbness
Cardiovascular		Musculoskeletal		Respiratory	
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Cough
<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Shortness of breath
Endocrine		Other symptoms		<input type="checkbox"/>	
<input type="checkbox"/>	Hair loss	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Temperature intolerance	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Abnormal hair growth	<input type="checkbox"/>		<input type="checkbox"/>	

When was your last menstrual period? _____

Have you had any serious illnesses, operations, or hospitalizations since your last visit?

Have you discovered any additional information about your family history that we should know?

Have you changed any habits (smoking, drinking, etc.) or occupation since your last visit?

Please list all current medications and doses including vitamins and herbals

Please list any current allergies: _____

Please briefly describe the reason for your visit today: _____
