HEALTH RECORD UPDATE Name_____ Date_____

DO YOU HAVE ANY OF THE FOLLOWING? Yes_____ No_____

GENERAL: chills, fever, night sweats, weight change, heat or cold intolerance, appetite change, fatigue, difficulty in stopping bleeding	**EYES**: vision changes, dry eyes
EAR, NOSE, THROAT: nosebleeds, sores in mouth, hoarseness, sore throat, ringing in ears, earache, sinus headache.	**CARDIOVASCULAR:** chest pains, heart attack, hypertension, stroke, rapid heartbeat, difficulty breathing with activity or lying down
RESPIRATORY: cough, shortness of breath, coughing up blood, wheezing	**GASTROS-INTESTINAL**: difficulty swallowing, blood in stool, change in bowel habits, tarry stools, abdominal pain, gall bladder problems, nausea, vomiting, ulcers, reflux, stomach problems
GENITOURNIARY: pelvic pain, blood in urine, loss of urine, increased frequency of night urination	**BONES, JOINTS**: leg cramps, painful feet, joint or muscle pain
SKIN: unusual growth of hair, moles, rashes, swollen lymph nodes, breast lump or pain in breasts, nipple discharge, easy bruising	**PSYCH:** depression, mood swings, sleep disturbances
NEURO: seizures, frequent headaches, dizziness	**ALLERGIES:**
OTHER:	

Do you want blood tests of any kind? Yes☐ No☐

Are you in a situation where you are being mentally, emotionally, or physically abused? Yes☐ No☐

What medications are you currently taking? (Include non-prescription vitamins and herbs)

Verify that this information is true and accurate to the best of my knowledge

_____ Interviewer_____

Signature of patient or legal guardian

DO NO WRITE BELOW THIS LINE for (Office Use Only)

CHIEF COMPLAINT:

MENSES: LMP Interval Duration IMB PC Pain PMS Discharge

HISTORY OF PRESENT ILLNESS: Location Quality Severity Timing
Context Modifying Factors Associate signs and symptoms Duration