MEDICAL HISTORY UPDATE

Please list any surgery, procedures, or new medical problems since your last visit:

_____

_____

Height_____ Weight_____

Current medications (include nonprescription drugs and vitamins): _____

_____

List all drug allergies: _____

List all physicians from whom you receive medical care: _____

_____

If applicable, date and results of last mammogram: _____

Do you use tobacco products?_____ Drink alcohol? _____ Use recreational drugs?_____

Please list any problems or concerns you would like to discuss: _____

_____

Do you now have or have you had in the past any communicable, transmittable or Infectious disease such as AIDS (HIV infection), tuberculosis or hepatitis?

Yes_____ No _____

Name_____ Phone_____

Address_____ City _____ St_____ Zip _____

Signature_____Date_____