ESTABLISHED PATIENT UPDATE

Location: ☐ Plano ☐ McKinney ☐ Allen ☐ Denison
Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Gender: _____
Primary Email: _____ Primary Phone Number: _____
Primary Care Physician: First Name: _____ Last: _____ City: _____
Briefly describe the Main reason for your visit today: _____
Please list all prescription medications you take regularly or as needed: (Name of Drug, Dose and Frequency of use): ☐ None

_____

_____

_____

Please list all Over the Counter (OTC) medications you take regularly or as needed: (Name of Drug, Dose and Frequency): ☐ None

_____

_____

List all FOOD allergies/intolerances: ☐ None _____
List all MEDICATION allergies/intolerances: ☐ None _____
List all INSECT or CHEMICAL allergies/intolerances: ☐ None _____
Have you received this season's FLU shot? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Have you ever received the Pneumonia shot Pneumovax? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Have you ever received the Pneumonia shot Prevnar 13? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Please indicate your preferred local Pharmacy NAME, CITY, STREET: _____
Do your prefer Liquid or Tablet medications? ☐ Liquid ☐ Tablet
Please list any NEW information regarding your health since your last visit? Indicate recent surgeries, illnesses, new diagnoses, etc:
☐ None _____
Have you had any changes in your social status since your last visit (job, residence, tobacco/alcohol use/ allergen exposure):
☐ Yes ☐ No If Yes, please specify: _____
Have you had any changes in your Family History since your last visit (relative with new illnesses or disease):
☐ Yes ☐ No If Yes, please specify: _____

Review of Systems/ Please select ANY signs/symptoms/conditions that you currently experience: ☐ None

Constitutional: ☐ Fatigue ☐ Night Sweats ☐ Fevers

GI: ☐ Indigestion ☐ Reflux ☐ Vomiting ☐ Diarrhea ☐ Trouble Swallowing

Frequent infections: ☐ Sinus ☐ Lung ☐ Ear/Throat ☐ Bronchitis ☐ Skin

Eyes: ☐ Blurry ☐ Itch ☐ Water ☐ Red ☐ Frequent Infections

Nose: ☐ Runny ☐ Stuffy ☐ Itchy ☐ Sneeze ☐ Loss of Smell

Skin: ☐ Dry ☐ Itch ☐ Swelling ☐ Rash ☐ Hives

Hematology: ☐ Unusual Bleeding ☐ Unusual Bruising ☐ Swollen Lymph Nodes

Respiratory: ☐ Short of Breath ☐ Wheeze ☐ Cough ☐ Croup ☐ Tight Chest

Urinary: ☐ Urinary Infection ☐ Blood in Urine ☐ Back Pain

Musculoskeletal: ☐ Stiff/Sore Joints ☐ Muscle Pain ☐ Red Swollen Joints

Chest: ☐ Slow Heart Rate ☐ Palpitations ☐ Tight ☐ Chest-Pain ☐ Fast Heart

Neuro: ☐ Numbness ☐ Seizures

Psychology: ☐ Anxious ☐ Depressed ☐ Stressed ☐ Worried

Endocrine: Weight ☐ Gain / ☐ Loss ☐ Increased Thirst ☐ Cold/ ☐ Heat Intolerance

My signature indicates that the above information is accurate to the best of my knowledge.

_____	_____	_____
Patient/Guardian Name	Patient/Guardian Signature	Date Updated

In office use: Reviewed by: JV GS MB TC AH LB LR

In office use: Signature of the Provider: _____