Scottsdale Family Health

Established Patient- Medical Update Form

Patient Name _____ Date of Birth _____ Today's Date _____

What brings you in to see the doctor today?

Please list pharmacy you would like us to use for your medications.

Pharmacy	**Phone Number**	**Fax Number**

Since your last visit:

1. Have you been diagnosed with any new medical conditions? ___Yes ___No

If Yes (give details)

2. Have you undergone any recent surgical procedures? ___Yes ___No

If Yes (give details)

3. Have you had any medication, vitamin or supplement changes? ___Yes ___No

4. Has there been any change in your family history? ___Yes ___No

If Yes (give details)

5. Do you currently smoke or use tobacco products? ___Yes ___No

6. Do you drink alcohol? ___Yes ___No

If yes, how many drinks _____ in a [day, week or month]

Medication List: (please list all medications you are taking ***OR ATTACH LIST***)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

[Note : include inhalers, nasal sprays, etc]

Allergy List: (please list all allergies you have to medications ***OR ATTACH LIST***)

Medication Allergy	Reaction

Provider List: (please list any other doctors/specialists you are seeing ***OR ATTACH LIST***)

Doctor	Specialty

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Check all that apply:

General- ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Trouble sleeping

Skin- ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness☐ Color changes ☐ Hair and nail changes

Head- ☐ Headache ☐ Head injury

Ears- ☐ Decreased hearing ☐ Ringing in ears (tinnitus) ☐ Earache☐ Drainage

Eyes- ☐ Vision Changes ☐ Glasses or contacts ☐ Pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights ☐ Glaucoma ☐ Cataracts

Nose- ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Nosebleeds☐ Sinus pain

Throat- ☐ Teeth issues ☐ Gums ☐ Bleeding☐ Dentures ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Non-healing sores

Neck- ☐ Lumps ☐ Swollen glands ☐ Pain☐ Stiffness

Breasts- ☐ Lumps ☐ Pain ☐ Discharge

Respiratory-☐ Cough ☐ Sputum☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Painful breathing

Cardiovascular-☐ Chest pain or discomfort ☐ Tightness ☐ Palpitations☐ Shortness of breath with activity ☐ Swelling in legs ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal- ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐Yellow eyes or skin

Urinary- ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine(hematuria) ☐ Incontinence ☐ Change in urinary strength

Genital-

Males Only -☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Sores ☐ Masses or pain ☐ Erectile dysfunction ☐ STD's

Females Only- ☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Itching or rash ☐ STD's

Vascular- ☐ Calf pain with walking (Claudication) ☐ Leg cramping

Musculoskeletal- ☐ Muscle or joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Trauma

Neurologic-☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tingling☐ Tremor

Hematologic- ☐ Ease of bruising ☐ Ease of bleeding

Endocrine- ☐ Head or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst

Psychiatric- ☐ Nervousness ☐ Depression ☐ Memory loss ☐ Stress