HISTORY UPDATE **NAME:** _____**DOB:** _____**DATE:** _____

What is your preferred Gender pronoun? She/Her, He/Him, They/Them please circle one

Have you been seen by another Doctor since your last Physical? ☐ NO ☐ YES Please list all: _____
_____

A. Since your last health maintenance exam, have you:

1. been hospitalized? _____ ☐ No ☐ Yes _____
2. had surgery?_____ ☐ No ☐ Yes _____
3. had an allergic reaction?_____ ☐ No ☐ Yes _____
4. had a major illness/accident? _____ ☐ No ☐ Yes _____
5. had a transfusion?_____ ☐ No ☐ Yes _____

Do you: 1. smoke?_____ ☐ No ☐ Yes -how much? _____
2. follow a special diet?_____ ☐ No ☐ Yes
3. drink alcohol?_____ ☐ No ☐ Yes -how much? _____ how often? _____
4. use other drugs?_____ ☐ No ☐ Yes _____
5. have guns in your home?_____ ☐ No ☐ Yes

Do you: 1. wear seat belts?_____ ☐ No ☐ Yes
2. wear a bike helmet?_____ ☐ No ☐ Yes
3. use sunscreen?_____ ☐ No ☐ Yes
4. have a living will?_____ ☐ No ☐ Yes

Any abuse or violence in your life?_____ ☐ No ☐ Yes
Any major changes in your family/personal life?_____ ☐ No ☐ Yes
Do you have a family history of drug/alcohol abuse?_____ ☐ No ☐ Yes
Are you an organ donor?_____ ☐ No ☐ Yes

Have you: *ever had a sexually transmitted disease?* ☐ *Yes* ☐ *No* ☐ *N/A*
Women have you: *ever had an abnormal pap?* ☐ *Yes* ☐ *No* ☐ *N/A*
Current occupation: _____ ***How Long?*** _____
Do you have any concerns today? _____
Since your last health maintenance exam, have any of the following symptoms been a problem for you?
PLEASE ANSWER ALL QUESTIONS BELOW:

HEAD & NECK:
☐ *Y* ☐ *N Headaches*
☐ *Y* ☐ *N Lumps or swelling*

EYES:
☐ *Y* ☐ *N Double vision*
☐ *Y* ☐ *N Decline in vision*
☐ *Y* ☐ *N Eyes water or itch*

EARS:
☐ *Y* ☐ *N Earache*
☐ *Y* ☐ *N Drainage*
☐ *Y* ☐ *N Noise in ears*
☐ *Y* ☐ *N Trouble hearing*

MOUTH:
☐ *Y* ☐ *N Taste changes*
☐ *Y* ☐ *N Soreness*
☐ *Y* ☐ *N Dental problems*

NOSE/THROAT:
☐ *Y* ☐ *N Bleeding*
☐ *Y* ☐ *N Frequent cold/sore throats*

CIRCULATION:
☐ *Y* ☐ *N Chest Pains*
☐ *Y* ☐ *N Chest tightness*
☐ *Y* ☐ *N Racing heart/palpitations*
☐ *Y* ☐ *N Leg cramps*
☐ *Y* ☐ *N Ankles/feet swelling*
☐ *Y* ☐ *N High blood pressure*

DIGESTIVE:
☐ *Y* ☐ *N Nausea*
☐ *Y* ☐ *N Gas*
☐ *Y* ☐ *N Heartburn/indigestion*
☐ *Y* ☐ *N Hard to swallow*
☐ *Y* ☐ *N Vomited blood*
☐ *Y* ☐ *N Loose bowels*
☐ *Y* ☐ *N Diarrhea*
☐ *Y* ☐ *N Constipation*
☐ *Y* ☐ *N Pain with stools*
☐ *Y* ☐ *N Grey or black stools*

SKIN:
☐ *Y* ☐ *N Dry-itchy*
☐ *Y* ☐ *N Rashes*
☐ *Y* ☐ *N Bruises easily*

MUSCLE/BONES:
☐ *Y* ☐ *N Back pain*
☐ *Y* ☐ *N Joint pain/stiffness*
☐ *Y* ☐ *N Muscle aches*

CONTRACEPTION:
☐ *None* ☐ *Pill* ☐ *IUD*

☐ *Condom* ☐ *Diaphragm*
☐ *Nexplanon* ☐ *Depo-Provera*

GENERAL:
☐ *Y* ☐ *N Fever*

Sexual Attraction: ☐ *Male* ☐ *Female*
☐ *Lesbian* ☐ *Gay* ☐ *Bisexual/Asexual*
☐ *Something else*
☐ *Don't know* ☐ *Declined to Specify*

LUNGS:
☐ *Y* ☐ *N Wheezing*
☐ *Y* ☐ *N Coughing*
☐ *Y* ☐ *N Coughing up blood*
☐ *Y* ☐ *N Shortness of breath*

NEUROLOGICAL:
☐ *Y* ☐ *N Fainting*
☐ *Y* ☐ *N Convulsions*
☐ *Y* ☐ *N Numbness*
☐ *Y* ☐ *N Falling/Unsteady Gait*
☐ *Y* ☐ *N Memory changes*
☐ *Y* ☐ *N Frequent dizziness*

GENITOURINARY:
☐ *Y* ☐ *N Pain with urination*
☐ *Y* ☐ *N Frequent urination-day*
☐ *Y* ☐ *N Frequent urination-pm*
☐ *Y* ☐ *N Hard to stop urine*
☐ *Y* ☐ *N Lack of control*
☐ *Y* ☐ *N Brown/Bloody urine*
☐ *Y* ☐ *N Problems with sex*

☐ *Y* ☐ *N Menstrual pain*
☐ *Y* ☐ *N Irregular periods*
☐ *Y* ☐ *N Heavy periods*
☐ *Y* ☐ *N Vaginal discharge*
☐ *Y* ☐ *N Breast Lump*
N/A _____

☐ *Y* ☐ *N Weak or slow urine flow*
☐ *Y* ☐ *N Prostate trouble*
☐ *Y* ☐ *N Lumps in testicles*
☐ *Y* ☐ *N Penile discharge*
N/A _____

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NAME: _____***DOB:*** _____***DATE:*** _____

In the past 30 days, have you had difficulty obtaining any of the following when it was really needed*?*

☐ ***Y*** ☐ *N Food* ☐ ***Y*** ☐ *N Clothing* ☐ ***Y*** ☐ *N Utilities* ☐ ***Y*** ☐ *N Housing*
☐ ***Y*** ☐ *N Transportation* ☐ ***Y*** ☐ *N Other*

PHQ-9*:*
Over the last 2 weeks, how often have you been bothered by any of the following problems?
Choose an answer of Not at all, Several days, More than half the days, or Nearly every day.

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. *Or the opposite --* *Being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

(Healthcare professional: For interpretation of TOTAL,
Please refer to accompanying scoring card.) ***TOTAL:*** _____

	Not difficult at all	*Somewhat difficult*	*Very difficult*	*Extremely difficult*
10. If you choose any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

When did the symptoms begin? _____

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