NEW HORIZONS INTERNAL MEDICINE
PATIENT MEDICAL UPDATE FORM

Name_____

Date of Birth_____

1) Since your last visit to our office, were you admitted to the hospital?
Yes No
If yes, please write where and when: _____

2) Have you had any medical test within the last year before or after your last visit?
Yes No
If yes, please check any that apply:

Mammogram (breast x-ray)	Pap smear (for women)	Colonoscopy
Blood work	X-rays	ECG / EKG (heart)
Vision	DEXA (checks for bone loss, or osteoporosis)	
MRI	CT ("CAT" scan)	other _____

List where and when you had the tests done_____

3) Since your last visit to our office, have you developed any new allergies or had a bad reaction to a medication or food?
Yes No
If yes, describe: _____

4) Since your last visit to our office, have you seen a specialist (such as a doctor for diabetes, heart, kidneys, cancer, eyes, gynecology, etc.)?
Yes No
If yes, who did you see and when?

Name	Approx. Date
Name	Approx. Date

5) Since your last visit to our office, have you had any vaccinations (shots)?
Yes No
If yes, check the shots you received:
Flu tetanus pneumonia
other - please list:_____

6) Since your last visit to our office, have you started any new prescribed medications?
Yes No
If yes, list: _____

_____**Your Signature and Today's Date**