RIVERSIDE FAMILY HEALTH
Caring For Your Whole Family

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Patient History Update

Name: _____ DOB: _____ Today's Date: _____

Since your last visit to our office:

1. Have you been seen at the emergency room or admitted to the hospital?

☐ No
☐ Yes
Date: _____
Hospital: _____
Date: _____
Hospital: _____
Date: _____
Hospital: _____

2. Have you had any medical tests?

☐ None
☐ Labs (Blood Work) - most recent
Date: _____
Facility: _____

☐ Mammogram
Date: _____
Facility: _____

☐ Pap Smear
Date: _____
Facility: _____

☐ Bone Density Scan (DEXA)
Date: _____
Facility: _____

☐ Colonoscopy
Date: _____
Facility: _____

☐ ECG/EKG
Date: _____
Facility: _____

☐ Vision
Date: _____
Facility: _____

☐ X-ray
Date: _____
Facility: _____
Body Part: _____

☐ CT/CAT Scan
Date: _____
Facility: _____
Body Part: _____

☐ MRI
Date: _____
Facility: _____
Body Part: _____

☐ Other
Date: _____
Facility: _____
Describe: _____

3. Have you developed any new allergies, or had a bad reaction to medication or food?

☐ No
☐ Yes
Describe: _____

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4. Have you seen a specialist?

☐ No
☐ Yes

Name/Specialty: _____

Most Recent Visit: _____

Name/Specialty: _____

Most Recent Visit: _____

Name/Specialty: _____

Most Recent Visit: _____

5. Please list all medications, prescription and over the counter, that you are currently taking:

Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____

Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____
Medication/Dose: _____

6. Have you had any vaccinations?

☐ None
☐ Flu
Date/Location: _____
☐ Pneumonia
Date/Location: _____
☐ Covid
Date/Location: _____
☐ Tetanus
Date/Location: _____
☐ Other
Describe: _____

Date/Location: _____

7. Have you been diagnosed with any new chronic conditions?

☐ No
☐ Yes
Problem: _____

Date/Who: _____

Problem: _____

Date/Who: _____

Problem: _____

Date/Who: _____