RIVERSIDE FAMILY HEALTH

Caring For Your Whole Family

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Phone (321) 453-5252 Fax (321) 453-5152

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: _____

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☐ CT/CAT Scan

Date: _____
Facility: _____
Body Part: _____

☐ Other

Date: _____
Facility: _____
Describe: _____

☐ MRI

Date: _____
Facility: _____
Body Part: _____

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

☐ No
☐ Yes

Describe: _____

4. Have you seen a specialist?

☐ No
☐ Yes

Name/Specialty:
_____

Most Recent Visit:
_____

Name/Specialty:
_____

Most Recent Visit:
_____

Name/Specialty:
_____

Most Recent Visit:
_____

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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: _____