Newborns To Geriatrics
RIVERSIDE FAMILY HEALTH PL
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Patient Information Update

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

Since your last visit to our office:

1. Have you been seen at an emergency room and/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: _____

4. Have you seen a specialist?

- ☐ No
- ☐ Yes

  Name/Specialty: _____

  Most Recent Date: _____

  Name/Specialty: _____

  Most Recent Date: _____

  Name/Specialty: _____

  Most Recent Date: _____

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: _____

Continue listing medications, if needed:

6. Have you had any vaccinations?

- ☐ None
- ☐ Flu

  Date/Location: _____

- ☐ Pneumonia

  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: _____