Trophy Club Family Medicine (817) 430-9111 UPDATE FORM rev 11/17

Name _____DOB ___/___/___ Date ___/___/___

Please list ALL current medications, vitamins, herbs or non-food supplements

Medication	Dose	Frequency		Medication	Dose	Frequency

Any significant changes in your health in the last year?

_____

_____

_____

Any new allergies or reactions to medications, or other agents since last visit?

☐ No ☐ Yes _____

Tobacco use ☐ Never smoked ☐ Current smoker ☐ Former smoker, quit date: _____

Total history of use: Average packs/day: _____ for #of years: _____.

Other tobacco: _____

Alcohol use Drink alcohol at all in past year ? ☐ No ☐ Yes: Average number per week: _____

Any use of **recreational drugs** in the past year? ☐ No ☐ Yes: _____

Average daily **caffeine** servings daily, type: _____

Exercise: Any regular exercise? ☐ Yes ☐ No. Type, hours per week:_____

Current occupation: _____

Average hours worked weekly including commute: _____

Activities and hobbies:_____

Marital status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed/er ☐ co-habitating

Sexually active ☐ Yes ☐ No sex partners are ☐ male ☐ female

Birth control method: _____

Any **updates to your family history** since your last physical? _____

_____

Name _____ DOB ____/____/____ Date____/___/____

Review of Systems (this is to check for past or recurring issues)

Constitutional:	Y	N
Chronic poor sleep		
Chronic fatigue, excessive sleepiness		
Chronic pain		
Unexplained weight loss or gain		
Neurologic:	Y	N
Recurring dizziness		
Headaches more than 3 per month		
Numbness or tingling		
Ever had seizures		
Significant memory loss		
Eyes/ears/nose/mouth:	Y	N
Eye issues (other than glasses)		
Recurring sinus infections		
Loss of hearing, ringing in ear		
Seasonal allergies		
Difficulty swallowing		
Respiratory:	Y	N
Recurring shortness of breath		
Frequent cough or wheezing		
Frequent or loud snoring		
Recurring lung infections		
Cardiovascular:	Y	N
Ever had bad chest pain		
High blood pressure		
High cholesterol or lipids		
Gastrointestinal:	Y	N
Recurring abdominal pain		
Recurring nausea, upset stomach		
Indigestion/heartburn		
Irregular bowel movements (normal is 3-14/week without straining)		
Difficulty swallowing; choking episodes		

Musculoskeletal:	Y	N
Frequent joint or bone pain		
Unexplained muscle pain		
Constant urge to move legs		
Leg swelling		
Skin:	Y	N
Recurring rash, itch		
Non-healing lesions, wounds		
Unexplained lumps or bumps		
Endocrine:	Y	N
Recurring irregular periods or cramps		
Excessive thirst, hunger		
Often feel too hot or cold		
Genitourinary:	Y	N
Difficulty starting stream		
Frequent or small voids		
Urinate more than twice per night		
Leaking urine		
Hematologic/Immunologic:	Y	N
History of non-pregnancy anemia		
Ever had blood clot, clotting disorder		
Ever had severe allergic reaction		
Psychiatric:	Y	N
Ever had major depression		
Anxiety, excessive worrying		
Frequent mood swings		
Sexual:	Y	N
Sexually active		
Erectile or vaginal issues		
Poor performance or low sex drive		
Breast or testicular lumps		
Other:		
Other:		