

## PATIENT HEALTH HISTORY UPDATE

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Gender Identity: \_\_\_\_\_

Occupation: \_\_\_\_\_

What is a goal that you have regarding your own health? *Nutrition, Physical Activity, etc.*

**Please help us update your medical record:**

**SURGICAL HISTORY** List any recent surgeries with date and place performed (include colonoscopy).

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**ADVANCED DIRECTIVE** Do you currently have an Advanced Directive?  Yes  No

### MEDICATIONS

Do you have any new medications you are taking, or have you changed your use of medications?  Yes  No

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*Please bring all of your current medications and supplements with you for your appointment.*

### SOCIAL HISTORY

**Substance Use:** Nicotine: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Marijuana: \_\_\_\_\_ Other: \_\_\_\_\_

**Sexual Life:** Active: \_\_\_\_\_ New Partner: \_\_\_\_\_ Prevention/Birth Control Method: \_\_\_\_\_

**Sexual Health Concerns:** \_\_\_\_\_

**Sleep Quality (concerns about sleep):** \_\_\_\_\_

Do you have any concerns regarding adequate food, clothing, housing or transportation?  Yes  No

Do you feel safe in your home (physically/emotionally/sexually)?  Yes  No

List anything about your health that you think your provider should know: \_\_\_\_\_

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### Exercise & Nutrition

What do you currently do for exercise? \_\_\_\_\_ Frequency: \_\_\_\_\_

Nutrition Changes: \_\_\_\_\_

*affix label here*

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_