Please update the below information:

Patient full name _____ Date: _____
Patient address _____
_____

Please update your current primary insurance:

Name of Insurance Company_____
ID#_____

Please list all prescriptions you are currently taking: Please include all over the counter drugs and vitamins:
Name : Dosage: Frequency:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently taking any over the counter blood thinners (i.e. Aspirin) ◯ Yes ◯ No

Allergy:_____**Reaction:** _____ **Allergy**:_____**Reaction:** _____

Allergy:_____**Reaction:** _____ **Allergy**:_____**Reaction:** _____

Please update your preferred pharmacy:
Pharmacy:_____ Phone:_____

Height: _____ **Weight**: _____

Health screening questions:

Have you had a flu shot this season? ◯ Y ◯ N If yes, Date/Month_____
Have you ever had an immunization for pneumonia? ◯ Y ◯ N If yes, Date/Month _____
Current cigarette smoker? ◯ Y ◯ N if yes: _____ packs/day
Former cigarette smoker? ◯ Y ◯ N if yes: _____ number of years

Have you fallen in the last year? ◯ Yes ◯ No (if yes, answer one of the two following questions)
I have fallen ONCE in the last year? ◯ Yes ◯ No
I have fallen MORE than once in the last year? ◯ Yes ◯ No
How long ago was your most recent mammogram? _____YEARS _____MONTHS ☐ NA
How long ago was your most recent pap smear? _____YEARS _____MONTHS ☐ NA
How long ago was your most recent colonoscopy? _____YEARS _____MONTHS ☐ NA
Name of primary/family doctor? _____ Last seen? _____ or NA ☐
Do you have a pain management doctor? If yes, who? _____

Signature _____
Dr. Review _____