Patient History Update

Magnolia Family Medicine

Providers (Please circle): ***Feras Elhajj, M.D.*** ***Christian Dyhianto, M.D*** ***Kathleen Paz, M.D.*** ***Kelci Evans, P.A***

Patient Name: _____ Today's Date: _____ DOB: _____ AGE: ___

I can be contacted at: E-mail Address: _____

Cell #: _____ Other #: _____ ( ) OK to leave message

General Health Questions (Please circle those that apply)

High Blood Pressure, Low Blood Pressure, Rapid Heart Rate, etc.	Y / N
High Cholesterol	Y / N
Difficult Breathing (COPD, Asthma, etc.)	Y / N
Digestive Disturbances (Indigestion, Constipation, Irritable Bowel Syndrome, etc.)	Y / N
Endrocrine (Diabetes, Thyroid, etc.)	Y / N
Chronic Pain Syndromes (Chronic Fatigue Syndrome, Fibromyalgia, etc.)	Y / N
I have had these symptoms/conditions for (please circle one): ***Current-3 months*** ***3-6 months*** ***More than 6 months***	

Bladder Function

Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?	Y / N
How often do you urinate; during the day? _____ times, during the night? _____ times	
Do you have to hurry to empty your bladder when full?	Y / N
Do you soil your clothing because you cannot make it to the bathroom in time?	Y / N
Do you use protective undergarments because you cannot hold your urine?	Y / N
I have had these symptoms/conditions for (please circle one): ***Current-3 months*** ***3-6 months*** ***More than 6 months***	

Nerve and Muscle Function

Seizures, Migraines or Other Headaches	Y / N
Have you been told that you have Neuritis or Neuropathy?	Y / N
Do you often have leg cramps?	Y / N
Do you have wounds on your legs that heal very slowly?	Y / N
Do you experience ANY of the following (***please circle those that apply***):	
Radiating Pain, Numbness, Tingling, Burning, Coldness, Sharp or Dull Pain in the :	
( ) Neck, Shoulders, Arms or Hands (i.e. Upper extremities)	Y / N
( ) Low Back, Hips or Legs (i.e. Lower Extremities)	Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands?	Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?	Y / N
I have had these symptoms/conditions for (please circle one): ***Current-3 months*** ***3-6 months*** ***More than 6 months***	

Balance & Fall Prevention

Do you ever lose your balance or feel dizzy or unsteady?	Y / N
Do you feel unsteady when walking or climbing stairs?	Y / N
Do you have any gait abnormalities (stumble or lose balance while walking)?	Y / N
Have you fallen more than once in the past year?	Y / N
Does dizziness or imbalance problems interfere with your job or your household responsibilities?	Y / N
Do you feel dizzy while ( ) sitting down or ( ) rising from a seated or lying position?	Y / N
I have had these symptoms/conditions for (please circle one): ***Current-3 months*** ***3-6 months*** ***More than 6 months***	

Cognitive & Brain Function

Have you ever lost consciousness? Y / N If so, was it due to Trauma? Explain.....	Y / N
Do You:	
Have feelings of Anxiety and/or Depression	Y / N
Have daily problems with memory or thinking (remembering important dates or assignments)?.....	Y / N
Have daily problems with making judgment's or decisions?.....	Y / N
Have less interest in hobbies and activities?.....	Y / N
Repeat the same things over and over again (questions, stories, statements) ?.....	Y / N
Have trouble learning how to use a tool, appliance or gadgets?.....	Y / N
Have trouble handling financial affairs (income taxes, paying bills)?.....	Y / N
Have trouble completing assignments or tasks?.....	Y / N
Have difficulty getting organized?.....	Y / N
Avoid getting started on a challenging task?.....	Y / N
Fidget or squirm with your hands or feet when you have to sit for a long time?	Y / N
Feel overly active or feel like you have to constantly do something, like you were driven by a motor?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	

Allergy & Immunology

Do you have any hay fever symptoms, such as sneezing, watery nasal drainage and nasal itching?	Y / N
Do you have persistent nasal congestion and/or post nasal drip?	Y / N
Do you have sinus problems, frequent colds, sinus headaches?	Y / N
Do your eyes itch, water, get red and/or swell?	Y / N
Do you have asthma, tight chest, and or persistent cough?	Y / N
Do you have skin problems such as eczema, hives or itching?	Y / N
Do your symptoms worsen when seasons change?	Y / N
Do your symptoms change when you go from indoors to outdoors?	Y / N
Are you symptoms worse in parks or grassy areas?	Y / N
Are your symptoms worse in the morning and/or after waking?	Y / N
Do your symptoms worsen when in contact with dust, while vacuuming, etc.	Y / N
Are your symptoms worse around animals?	Y / N
Do you have close relatives with allergies?	Y / N
Are you aware of any Food Allergies that you may have?.....	Y / N
Do you take medications to control your allergies? If so, describe: _____	
Do they help?	Y / N
I have had these symptoms/conditions for (please circle one): Current-3 months 3-6 months More than 6 months	

Major Accidents/Traumas: _____

Major Surgeries: _____

Medications: _____

Any other General Health Issues: _____

This Patient History Update, which will be part of your medical record, lists symptoms and other factors that may allow your physician to recommend one or more diagnostic studies to better manage your care. Upon review and approval, you may be contacted by our Medical Services Scheduling Company to schedule these tests.

Patient Signature: _____ Date: _____

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