ANTHONY J. BARONE, M.D

PATIENT HEALTH UPDATE FORM

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Telephone:_____ Cell Phone:_____ Work:_____

In Case of Emergency – Name:_____ Relationship:_____ Telephone:_____

Email address:_____

MEDICAL HISTORY: *Please check off health conditions for which you are being treated or take medication for:*

__High Blood Pressure	__Bleeding Problems	__Arthritis	__Psychiatric Problems	__Cancer
__High Cholesterol	__Heart Disease	__Liver Problems	__Back/Neck Pain	__Diabetes
__Tuberculosis	__Kidney Problems	__Osteoporosis	__HIV/AIDS	__Asthma
__Stomach Ulcer	__Heart Attack	__Blood Clots	__COPD/Emphysema	__Anemia
__Thyroid Problems	__Vascular Problems	__Seizures/Epilepsy	__Stroke	

MAJOR SURGERIES SINCE YOUR LAST VISIT: *(Please list procedure and year)*

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS: (*Please list all current medications – include over the counter - or provide a list for us to copy and attach)*
If you do not take any medication, please circle - I TAKE NO MEDICATION

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ARE YOU ALLERGIC TO ANY MEDICATION(S): _____ *if NONE, please circle:* NKDA

Do you smoke tobacco? Yes/No/Quit How many packs per day? _____For how many years: _____
Do you drink alcohol? Yes/No Frequency/Quantity:_____

PLEASE CHECK ANY SYMPTOMS YOU *ARE EXPERIENCING AT THIS TIME*: *(Review of Systems)*

CONSTITUTIONAL:	__Fever	__Chills	__Night Sweats	__Sudden Weight Gain/Loss	
NEUROLOGICAL:	__Headache	__Dizziness	__Fainting		
EYES:	__Eye Pain	__Vision Changes	__Tearing/Itchy Eyes		
ENT:	__Hearing Loss	__Ear Pain	__Ear Discharge	__Ringing in Ears	__Nasal Congestion
	__Runny Nose	__Nasal Bleeding	__Hoarseness	__Difficulty Swallowing	__Sore Throat
NECK:	__Swollen Glands	__Neck Mass/Lump			
CARDIOVASCULAR:	__Chest Pain	__Palpitations			
PULMONARY:	__Cough	__Wheeze	__Shortness of Breath		
GASTROINTESTINAL:	__Abdominal Pain	__Nausea	__Vomiting		
SKIN:	__Rash	__Unexplained Bruising			
PSYCHIATRIC:	__Intent to Harm Self				

FAMILY HISTORY: **HAVE MEMBERS OF YOUR FAMILY EXPERIENCED ANY OF THE FOLLOWING?** *(Circle all that apply):*

Environmental Allergies	Sinus Problems	Chronic Headaches	Head/Neck/Throat Cancer
Hearing Loss	Sleep Apnea	Vertigo/Dizziness	Bleeding Problems

PATIENT SIGNATURE: _____ **DATE:** _____