Family Therapy Clinic

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Medical Update Form

Review of Systems: Please indicate if you have experienced any of the following symptoms since your last visit.

□ No Symptoms

Constitutional
□ Daytime Fatigue/ Sedation
□ Insomnia
□ Excessive Sweating
□ Excessive Thirst
□ Weight Loss
□ Weight Gain
□ Other_____

Cardiovascular
□ High Blood Pressure
□ Heart Palpitations
□ Rapid Heart Beat
□ Chest Pain
□ Lower Extremity Edema
□ Other_____

Respiratory
□ Shortness of Breath
□ Cough
□ Wheezing
□ Asthma
□ Bronchitis
□ Other_____

Eyes
□ Excessive Tearing
□ Eye Pain
□ Double Vision
□ Blurred Vision
□ Loss of Vision
□ Glaucoma
□ Cataracts
□ Other_____

Ear, Nose, Mouth, Throat
□ Ear Ringing
□ Earache
□ Hearing Loss
□ Sore Throat
□ Nasal Discharge
□ Sinus Congestion/ Rhinitis
□ Nosebleeds
□ Bleeding Gums
□ Dry Mouth
□ Other_____

Gastrointestinal
□ Heart Burn
□ Abdominal Pain
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Gallbladder Problems
□ Other_____

Genitourinary
□ Burning Urination
□ Blood in Urine
□ Urinary Infections
□ Urinary Incontinence
□ Increased Urination
□ Decreased Urination
□ Kidney Stones
□ Sexual Dysfunction
□ Change in Libido
□ Other_____

Skin
□ Rashes
□ Sores
□ Lumps
□ Dryness
□ Itching
□ Hives
□ Bruising
□ Other_____

Musculoskeletal
□ Muscle Pain
□ Muscle Weakness
□ Joint Pain/Stiffness
□ Back Pain
□ Difficulty Walking
□ Limb Paralysis
□ Other_____

Blood or Lymph
□ Anemia
□ Easy Bruising
□ Easy Bleeding
□ Swollen Glands
□ Other_____

Neurological
□ Headaches
□ Dizziness
□ Blackouts
□ Seizures
□ Tremor
□ Numbness/Tingling
□ Memory Problems
□ Concentration Problems
□ Other_____

Psychological
□ Anxiety/Nervousness
□ Panic
□ Obsessive Thinking
□ Compulsive Behavior
□ Negative Mood/Depression
□ Mood Fluctuations
□ Insomnia
□ Low Motivation/Lethargy
□ Hallucinations
□ Paranoia
□ Suicidal Thoughts
□ Homicidal Thoughts
□ Violent Behavior
□ Traumatic Stress
□ Other_____

Medication: Please list any prescription or over-the-counter medications, herbals, & nutritional supplements that you have either (**S**)tarted, (**C**)hanged, or (**D**)iscontinued since your last visit *(list additional medications on back).*

□ No Medication Updates

Medication Name	Started (S) Changed (C) Discont. (D)	Dose	How & When Taken *(e.g., by mouth twice a day; sublingually in the morning; apply patch at bedtime)*

□ No Known Drug/Food Allergies Allergies:_____

Illicit Drug Use: □ Yes □ No *(If Yes, list type/s* _____*)*

Alcohol Use: □ None □ Occasional/Social Daily Use: □ < 3 □ 3-4 □ 4-7 □ > 7

Females Only: Possibly pregnant? □ Yes □ No *(If Yes,* _____ *weeks pregnant)*

Use of birth control? □ Yes □ No *(If Yes, list type* _____*)*

_____ _____

Patient Printed Name ***Date***