PATIENT INFORMATION UPDATE SINCE LAST VISIT **(MUST BE FILLED OUT EVERY VISIT)**

**Name: _____D.O.B._____ Date: _____**

**Since your last visit, were you admitted to the hospital?** ___ Yes or ___ No

**If yes, where and when?**_____

1. **Since your last visit, have you had any medical tests done?** __ Yes or __ No

   **If yes, please check any that apply:**

   __ Mammogram (Breast X-Ray) __ Colonoscopy __ Other

   __ Blood Work __ ECG/EKG (Heart)

   __ DEXA Scan (Bone Density) __ Imaging/Radiology

   **List where and when you had these test done:**

   _____

2. **Since your last visit, have you seen a specialist (endocrinologist, cardiologist, nephrologist, neurologist, pulmonologist, ophthalmologist)?**

   Name/Specialty/Date of Visit:

   _____

   _____

3. **Since your last visit, have you had any vaccinations (shots)?**

   __Yes or __No __Flu __Tetanus __Pneumonia __Shingrex __Other

4. **Since your last visit, have you started or discontinued any medications?**

   **Started:** _____

   **Discontinued:** _____

5. **Preferred Pharmacy:** _____

6. **Address/Phone # of pharmacy** (If not in our file)**:**

   _____

7. **Do you need medications refilled? If yes, to which pharmacy?** (Please List)

   _____

   _____

8. **Anything else you would like to add:**

   _____

**For staff use ONLY:**

**BP= _____ P= _____ O2%= _____ T= _____**

**R. BP= _____ WGT= _____ HGT= _____**