

**Patient History Update:**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Language: English  Spanish  Indian  Japanese

Chinese  Korean  French  German  Russian  Other

Race: White  American Indian or Alaska Native  Asian  Hispanic or Latino

Native Hawaiian/other Pacific Islander  Black or African American

Ethnicity: Hispanic or Latino  Not Hispanic or Latino  Decline to Answer

Are you seeing anyone else for other problems or health conditions? Yes  No

Please list the problem, date the problem began and provider treating you for this condition:

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**Past health history:**

If yes, include date & provider seen

Have you been diagnosed with Hypertension? Yes  No  \_\_\_\_\_

Have you been diagnosed with Diabetes? Yes  No  \_\_\_\_\_

Type I \_\_\_\_\_ Type II \_\_\_\_\_

**Vitals:**

What is your usual blood pressure? \_\_\_\_\_

Height? \_\_\_\_\_ Weight? \_\_\_\_\_

*\*If you are unsure, please let us know so that we can take it for you*

**Medications:** (What Medications are you currently taking? Include vitamins, herbs, minerals. List date started, brand name, generic name, strength, dosage, quantity, refills available, prescribed by. Please be as specific as possible)

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Do you have any allergies?  Food  Environmental  Medication

List types of allergy reaction: \_\_\_\_\_

Do you Smoke?  Never  Former smoker  Current/every day smoker

Current some day smoker