ANNUAL MEDICAL INFORMATION UPDATE

Please update our records

Patient Name ____
FIRST MIDDLE LAST

Address ____

____

Home Phone Number ____________________ Cell Phone Number ____________________

Work Phone Number ____________________ Ext _____

E-mail address ____________________ _____You may contact me via the internet

ALLERGIES to LATEX ☐ **yes** ☐ **no** **ALLERGIES to MEDICATIONS** ☐ **yes** ☐ **no**

List:____

____

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CURRENT MEDICATIONS (include herbs & vitamins)

List:____

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Smoking Status: Currently Smoking ☐ yes ☐ no
Currently using Nicotine Patch or Gum ☐ yes ☐ no

Describe in detail any of the following items marked (YES) and any other changes in your medical status:

MVP(Mitral Valve Prolapse) ☐ yes ☐ no
Cancer ☐ yes ☐ no
Diabetes ☐ yes ☐ no
Thyroid Changes ☐ yes ☐ no
Dry Eye ☐ yes ☐ no
Cardiac Changes ☐ yes ☐ no
HIV ☐ yes ☐ no
Hepatitus B, C, other ☐ yes ☐ no
Recent Surgery ☐ yes ☐ no

Mental Status/Life Changes (depression, anxiety, divorce, death of spouse) ☐ yes ☐ no
Other Medical Changes (pregnancy, asthma, etc…) ☐ yes ☐ no

Explanation of any items marked YES

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Patient Signature____

Date: ____________________

Update entered to IMS ____________