Interval History Form

Name_____
Date of birth_____
Today's Date_____

Reason for visit _____

Describe symptoms Include duration and anything that makes symptoms better or worse

_____

Allergies or Intolerances to Medications_____

Have you had any **LABS** or **X-Rays** since your last appointment? Yes. No
If so , what and where_____

Have you seen any other doctors or been hospitalized since your last appointment? Yes. No
If yes list name of doctor, for what reason, and if any testing done

_____

All medication bottles should be brought to your appointment

Have you been started on any new medications since your last appointment? Yes No

If yes, please list _____

Have you stopped any medications since last appointment? Yes No
If yes, please list

_____

Describe your diet : _____

Describe your exercise routine:_____
You should be exercising 30 minutes five times per week

For women of child bearing age when was your last menstrual period :

Please list refills you may need :

_____

_____

Name and street or phone of preferred pharmacy _____

Last colonoscopy if over age 50 _____
Last mammogram if over 40_____
Last pap smear _____
Last pneumovaccine if over age 65 _____
Last eye exam _____
Last influenza vaccine _____
Do you Smoke? yes no (circle one) If you used to smoke when did you quit ?
Have you fallen in the past year Yes No (circle one)
Are you depressed Yes No (circle one) If yes please fill out PHQ9 form.