MRN#		

Update Medical History Age 13 and older



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Marking Instructions														
Please use a #2 pencil.	PLEASE	PRINT F	PATIEN	T'S FIR	ST NAI	ME		PATIE	NT'S	DATE	OF E	BIRTH	l	
Fill in the complete oval as shown														
								Month		Day			Yea	r

Please complete this history form. This will allow us to serve your health needs. information contained herein is strictly confidential and will not be released unless you authorize us to do so

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			you) smoke			less	than 5	5	10	15	20	25	30	35	40+
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OTHER			`												
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Other D	isease, Cand	cer or Signif	ficant Medic	ai iliness (pl	ease spe	city):									

MRN#			

Update Medical History Age 13 and older

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Colonoscopy Pap Smear Bone Density / Dexa Scan Prostate Cancer Screening Stool Hemoccult (blood in stool) Eye Exam **Please review your medication list with the nurse and make corrections if needed.** Please list any new allergies we should know about: Please list any other physicians you have seen in the last year, so that we can obtain your records:	Mammogran		50			1	1010	101			
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Prostate Cancer Screening Stool Hemoccult (blood in stool) Eye Exam MEN ONLY Any problems with erectile dysfunction? yes no n/a **Please review your medication list with the nurse and make corrections if needed.** Please list any new allergies we should know about: Please list any other physicians you have seen in the last year, so that we can obtain your records:			510		ÖÖ	1	5101	510			
Stool Hemoccult (blood in stool) Eye Exam MEN ONLY Any problems with erectile dysfunction? yes no n/a **Please review your medication list with the nurse and make corrections if needed.** Please list any new allergies we should know about: Please list any other physicians you have seen in the last year, so that we can obtain your records:			50	00	olo	,10	500	510	L		
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	Please list any hospital admissions ,	/ emergenc	y room v	visits you h	ave had i	n the	e last year.	List the r	reason(s).		