

Katz and Kade, Inc.
71 E. Hollister St.
Cincinnati, Oh 45219

MEDICAL HISTORY UPDATE

Name: _____ DOB: ___/___/___ Date: ___/___/___

Email: _____ Religion: _____

Marital Status (please circle): Single Married Divorced Separated Widowed

Do you consider yourself to be: ___ Hispanic or Latino ___ Non-Hispanic or Latino

Do you consider yourself to be: ___ White

___ Black or African American

___ Asian

___ American Indian or Native Alaskan

___ Native Hawaiian or Pacific Islander

What is your preferred language? ___ English ___ Spanish ___ Other; please specify: _____

If not English, do you require an interpreter? _____

Pharmacy name & location: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Specialty Physician: _____ Phone #: _____

VACCINATIONS

Influenza (flu)	Approximate date received:
Herpes Zoster (shingles)	Approximate date received:
Pneumococcal (pneumonia)	Approximate date received:
DTaP (diphtheria, tetanus, pertussis)	Approximate date received:
Tetanus	Approximate date received:

First day of your last menstrual period: ___/___/___		
Contraceptive method, if applicable:		
New medications or medication changes, including over-the-counter medications:		
New medical problems, hospitalizations, surgeries or fractures:		
	Yes	No
Is there a new family history of blood clots, breast or ovarian cancer?		
Are you currently sexually active?		
If not currently sexually active, have you ever been sexually active?		
Are you having any sexual issues? (pain, decreased libido, etc.?)		
Have you had a new partner since your last visit?		
Have you been abused, harmed or threatened by anyone including your partner since your last visit?		
Do you use tobacco (smoke or chew)? If so, how much per day:		
Do you drink alcohol? If so, how many drinks per week:		
Do you exercise regularly? If so, what do you do:		

Are there any issues you would like to have addressed today? _____

Patient signature: _____ Date: ___/___/___

Physician signature: _____ MD Date: ___/___/___