Island Health Care

PATIENT MEDICAL HISTORY UPDATE FORM for DOT EXAM

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

MEDICATION ALLERGIES

□ None □ Yes, please list _____

FAMILY HEALTH HISTORY

Relation to you	Age	Health Status	Significant Health Problem
Father		□ In good health □ In stable health □ In poor health □ Deceased	
Mother		□ In good health □ In stable health □ In poor health □ Deceased	

Any other pertinent family medical history:_____
_____

IMMUNIZATION HISTORY

Flu Shot? Date: _____ Where: _____ (Note flu season is 10/1 – 3/31)

Tetanus/TD/TDaP? Date: _____ Where: _____

CANCER SCREENINGS

Ages 50 – 85 only:
Colonoscopy date: _____ Where: _____ □Never

Women only:
Pap smear date: _____ Where: _____ □Total Hysterectomy

TOBOCCO USE

□ Never smoked □ Light smoker □ Heavy smoker □Former smoker
How many years quit?____ # of yrs:_____
□ Cigarettes___ pks/day □ Chew__#day □ Pipe__#day □ Cigars__ #day
(Include electronic cigarettes)