Evia Medical Center

100 Terry Road
Smithtown, NY 11787

Updated Medical History (Since Last Visit)

Today's Date:	**Patient Name:**
List any **new medical problems** or concerns: 1.	2. 3.
Have you seen any **specialists** since your last visit here?	YES _____ NO _____
If "YES" :	Name of Specialist: _____ Recommendations they made: _____ _____ _____ _____
Have you been **hospitalized** since your last visit here?	YES _____ NO _____
If "YES" :	Where : _____ When: _____ Reason for Hospitalization: _____ _____

Please Provide current list of **Medications, Supplements and doses**

** Please check box if you need a refill

NOTE: We have many supplements in stock. Please ask at check out.

Medication/Supplement Name	Dose	How Often	Need Refill

Med/Supplement List (Continued) ** Please check box if you need a refill **NOTE**: We have many supplements in stock. Please ask at check out.	Medication/Supplement Name	Dose	How Often	Need Refill
Do you have any **allergies to medications**?	YES _____ NO _____			
If "YES" :	Allergy: _____ Allergy: _____ Allergy: _____			
Have you had **recent lab work**?	YES _____ NO _____			
If "YES" :	Where: _____ When: _____			
When was your **last colonoscopy**?	When: _____ Gastroenterologist's Name: _____			
For WOMEN:	When was your **last PAP?** _____ Gynecologist's Name: _____ When was your **last Mammogram?** _____ Who ordered it: _____ When was your **last Bone Density Scan?** _____ Who ordered it: _____			

Additional Comments:

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