# Associated Medical Specialists, PA, d/b/a Coastal Cancer Center
# Patient Medical History Update

Last _____ First _____ DOB: _____ Chart # _____

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Chief Complaint and History of Present Illness: What is the main reason for your visit today?

_____

_____

List any **new** problems or symptoms within the past 12 months: _____

_____

_____

List any **new** hospitalizations or procedures within the past 12 months: _____

_____

_____

List any **new** allergies, (drugs, food, pollens, etc.), within the past 12 months:

| Item | Describe reaction you had |
|---|---|
| _____ | _____ |
| _____ | _____ |

List any **changes** in family or social history, (marital, smoking, new diagnosis, etc.), within the past 12 months:

_____

_____

When was your last Flu vaccination? _____ Pneumonia vaccination? _____

Please discuss with your care team member **any changes in your medications** within the past 12 months.

**Primary Care** Physician: _____ Phone #: _____

City/State: _____ Group Name: _____

**Other** Physician: _____ Specialty: _____

City/State: _____ Group Name: _____

**Other** Physician: _____ Specialty: _____

City/State: _____ Group Name: _____

**Pharmacy**: _____ Phone #: _____

Do you have an Advance Directive (Living Will)? ☐ Yes ☐ No If Yes, please provide a copy

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

☐ enter PROVIDER signature date in RO initials _____ SCAN in IKM 3/01/2018