



THE UNIVERSITY OF ARIZONA
MEDICAL CENTER

University Campus

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MEDICAL RECORD#

DOB

NAME

VISIT#

ESTABLISHED VISIT CHART UPDATE

REASON FOR VISIT:

CHANGES IN SYMPTOMS SINCE LAST VISIT INCLUDING ADDITION OF NEW MEDICATIONS:

PAST MEDICAL HISTORY:

PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE AND TIMES PER DAY):

<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>

LIST ANY **ALLERGIES** TO MEDICATIONS:

CHECK HERE IF NO CHANGES IN GENERAL HEALTH SINCE LAST VISIT

NEW MEDICAL PROBLEMS SINCE LAST VISIT:

RECENT SURGERIES:

ER VISITS / LAB TESTING / RADIOLOGY IMAGING:

SOCIAL HISTORY / FAMILY HISTORY:

CHECK HERE IF NO CHANGES IN SOCIAL OR FAMILY HISTORY SINCE LAST VISIT

CHANGES SINCE LAST VISIT (STOPPED/STARTED SMOKING, CHANGE IN WORK OR MARITAL STATUS, ETC):

REVIEW OF SYSTEMS:

CHECK HERE IF NO CHANGES IN REVIEW OF SYSTEMS SINCE LAST VISIT

		Yes	No	Current		Yes	No	Current
GENERAL	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss <input type="checkbox"/> or gain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus/Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wear Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Reviewed by: _____ Date: _____ Military Time: _____