Karle Medical Group, P.C.
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Patient Information Update

Your Karle Medical Group Doctor: _____ Date: _____

Patient Information

Last Name _____First Name _____MI_____ Date of Birth _____

1. Since your last visit to our office, were you admitted to the hospital? Yes No

2. Since your last visit to our office, have you been to the Emergency Room or Urgent Care? Yes No

   If yes, where and when (date): _____

3. Since your last visit to our office, have you had any medical tests? Yes No
   If yes, please check any that apply:

   ☐ Mammogram ☐ Pap Smear ☐ Colonoscopy
   ☐ Blood work ☐ X-rays ☐ EKG
   ☐ Vision Screening ☐ DEXA (Bone scan) ☐ Surgery:_____
   ☐ MRI ☐ CT (CAT) Scan ☐ Other Test:_____

   Where did you have testing or surgery done? _____

4. Since your last visit to our office, have you developed any new allergies or had a bad reaction to a medication or food? Yes No

   If yes, describe: _____

5. Since your last visit to our office, have you seen a specialist? Yes No
   If yes, who did you see and when:

   Specialist Name: _____Phone:_____ Date: _____

   Specialist Name: _____Phone:_____ Date: _____

   Specialist Name: _____Phone:_____ Date: _____

6. Since your last visit to our office, have you had any vaccinations? Yes No

   If yes, what immunizations: _____Date: _____

7. Since your last visit to our office, have you started any new prescription medications? Yes No

   If yes, list medications: _____

   _____

Signature: _____ Date:_____