



3300 Northwest 56th Street
 Suite 300
 Oklahoma City, OK 73112-4401

Name:

DOB:

Date:

We ask that our returning patients please take a few moments to fill out this form to help us update your records.

Please list any new medical problems:

Please list any surgeries you have had since your last visit:

Do you have any new medical problems in your family? If so, what are they?

Please list all current medications:

Please list all allergies you have:

Do you smoke?	NO	YES	How much?		
Do you drink alcohol?	NO	YES	How much?		
Do you use street drugs?	NO	YES	Do you have problems with violence at home?	NO	YES

Please check any that may apply:

General:	Weight Loss	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
HEENT:	Vision Change	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>		<input type="checkbox"/>
CV:	Chest Pain/Pressure	<input type="checkbox"/>	Irregular Heart Beats	<input type="checkbox"/>	Swelling of Legs	<input type="checkbox"/>		<input type="checkbox"/>
Resp:	Shortness of Breath	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Spitting of Blood	<input type="checkbox"/>		<input type="checkbox"/>
GI:	Bloody Stool	<input type="checkbox"/>	Nausea/Indigestion/Vomitting	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Spitting of Blood	<input type="checkbox"/>
Urinary:	Frequency	<input type="checkbox"/>	Pain with urination:	<input type="checkbox"/>	Loss of Urine:	<input type="checkbox"/>		<input type="checkbox"/>
MS:	Muscle pain	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>		<input type="checkbox"/>
Skin:	Rash	<input type="checkbox"/>	Change in Size/color/shape of a mole	<input type="checkbox"/>				
Neuro/psych:	Headaches:	<input type="checkbox"/>	Depression/crying spells	<input type="checkbox"/>				

Do you perform monthly self breast examination?	NO	YES
When did you have your last cholesterol blood test? _____		
For those over 40, when was your last colonoscopy or test for blood in stool? _____		
Does your insurance cover routine, preventative gynecological care?	NO	YES

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