Optimal Health Physicians
15235 Shady Grove Road, Suite 102, Rockville, MD 20850
Phone: (301) 330-9430 Fax: (301) 330-6515 www.ohpmd.com admin@ohpmd.com

Patient Health Update

Please submit to OHP three working days prior to each office visit or telephone consultation.

Name _____ DOB _____ Today's Date _____

Next Scheduled Office Visit or Phone Consultation: With _____Date _____ Time_____

Value of Submitting Your Health Updates

Optimal Health Physicians believes that you are the best source of information about your health, and we firmly believe that only with your active participation in your care can you receive the full benefits of our knowledge, experience and care. When we see you in the office, talk by phone or exchange messages, we really only get snapshots of your progress, changes and concerns. Even when we string these snapshots together, our knowledge of your progress or changing conditions may still be sporadic or incomplete. In complex medical conditions, even subtle patterns of change day-to-day can be valuable tools in diagnosis and treatment.

Again, you are the only source of this information. To ensure we have a comprehensive view of your health and that you come to your visits prepared to discuss all of your concerns in detail, **we strongly urge you to keep a record of changes in your health** and send this form to us by fax or mail several days prior to being seen in the office or prior to telephone consultations. We make every effort to review this information in our daily clinical conferences prior to your visits.

Have your changed your Primary Care Provider? ☐ Yes ☐ No

New Provider's Name _____ Phone_____

Address: _____

Have you changed your Pharmacy? ☐ Yes ☐ No

New Pharmacy's Name _____ Phone_____ FAX _____

Address: _____

Key Concerns & Issues

Please describe key concerns or issues you would like to discuss (e.g. changes in Rx)

Concern or Issue	Comments

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Allergies

Please list and new or changed allergies or intolerances.

Allergy or Intolerance	Reaction

Symptoms

Please list your main symptoms, old or new (e.g. muscle ache). Indicate on a scale of 1-10 the severity of this symptom where 1 = very slight and 10 = as bad as you feel it can be. Also indicate if this rating indicates to you that the symptom is getting better or worse.

Symptom	Symptom Rating	Better or Worse	When Change Occurred or Occurs	What Makes this Better or Worse?

Prescription Medications & Over-the-Counter Medicines

Please list all current prescriptions from all of your physicians, and all OTC medicines you are taking.

Medication Name	Dose	Frequency	Comments

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Therapeutics

Please list all current therapeutic or nutritional supplements you take.

Product	Dose	Frequency	Comments

Health & Wellness Practices

Please describe any complimentary approaches you follow (e.g. meditation, acupuncture, yoga).

Practice	Frequency	Comments