Beebe Healthcare Medical Group

Beebe Primary Care - Lewes

Today's Date: _____

Health History

Patient Name _____ Birthdate _____ Age _____

Date of last physical exam _____ Former Primary Care Physician: _____

Pharmacy: _____ Durable Medical Equipment Co _____

Past Medical/Surgical history Have you had? (mark box ☒)	**Review of Systems** Do you have? (mark box ☒)	
❑ Heart Trouble	❑ Chest pain	❑ Skin rash
❑ MI/Heart Attack	❑ Palpitations	❑ Itching
❑ Angina/chest pain	❑ Shortness of breath	❑ Varicose veins
❑ Shortness of breath	❑ Weight loss	❑ Swelling of legs
❑ Blood pressure problems	❑ Fever, chills	❑ Breast lump or discharge
❑ Asthma	❑ Weakness, fatigue or tiredness	❑ Anemia
❑ Bronchitis, emphysema	❑ Blurred vision, eye discharge	❑ Seasonal allergies
❑ Seizure disorder	❑ Earache or ear discharge	❑ Recurrent infections
❑ Liver problems	❑ Sore throat or oral lesions	❑ Headache
❑ Thyroid problems	❑ Stuffy nose or post nasal drip	❑ Seizures
❑ Diabetes	❑ Cough/sputum production	❑ Tremors
❑ Arthritis, joint or back pain	❑ Heartburn	❑ Memory Loss
❑ Stroke (What weakness do You have from the stroke?? _____	❑ Constipation or Diarrhea	❑ Frequent falls
	❑ Bloody/tarry stools	❑ Anxiety
	❑ Stomach pain	❑ Depression
❑ Kidney problems	❑ Difficulty controlling urine	❑ Bipolar disorder
❑ Alzheimer's, other brain disease	❑ Blood in urine	❑ Snoring at night
❑ History of cancer Type: _____	❑ Sexual problems	❑ Daytime sleepiness
	❑ Joint pains	❑ Hearing problems:
Type: _____	❑ Back pain	❑ Other problems:
❑ HIV positive or AIDS	❑ Hot flashes	_____
❑ Other:	❑ Hair loss	
	❑ Sleep Apnea ❑ CPAP	

List Previous Biopsies, Endoscopies and Surgeries (Type and Date)
1.
2.
3.
4.
5.
6.
7.

Date of Last:		
Pap:	Mammogram:	Bone Density:
PSA:	Colonoscopy:	Complete Bloodwork:

Occupation (if retired, occupation before retirement):	
Education Level:	Difficulty Reading? ❑ Yes ❑ No

Please see other side →

Social History – Do you?			
❑ Smoke	# packs per day:	# years:	❑ Quit When did you quit?
❑ Drink alcohol	# drinks per day/week		❑ Recreational drug use
❑ Victim of abuse/neglect			

Family History				
Relative	Age (if living)	Age/Year of Death	Current Illness	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				

Current Medications		
Drug name	Dose	Time of day taken

Medication Allergies	Vaccines
Include Drug Name and Reaction	Flu: ❑ No ❑ Yes Date:
	Pneumonia: ❑ No ❑ Yes Date:
	Prevnar 13: ❑ No ❑ Yes Date:
	Shingles: ❑ No ❑ Yes Date:
	Tetanus: ❑ No ❑ Yes Date:
Living Will? ❑ Yes ❑ No	Other:

Patient Name: _____ Date of Birth: _____