BEEBE MEDICAL GROUP PULMONARY AND SLEEP DISORDERS

PATIENT HISTORY INFORMATION

Today's Date:__________________ Patient Name:____ Age: ________

Birthdate:________________ Current Lab:__________________ Current Pharmacy: __________________________

Current Imaging Center:_______ __________________________ **HEIGHT**:________________ **WEIGHT**:_____________

Past Medical/Surgical history Have you had? (mark box ☒)	Review of Systems Do you have? (mark box ☒)	
❑ MI/Heart Attack	❑ Chest pain	❑ Skin rash
❑ Angina/chest pain	❑ Palpitations	❑ Itching
❑ Shortness of breath	❑ Shortness of breath: w/lying flat or with exertion	❑ Seasonal allergies
❑ Blood pressure problems	❑ Sleep Apnea ❑ CPAP	❑ Anemia
❑ Asthma	❑ Unintentional weight loss	❑ Recurrent infections
❑ Bronchitis, emphysema, TB or other lung disease.	❑ Fever > 100°	❑ Headache
❑ Seizure disorder/fainting	❑ Blurred or double vision	❑ Seizures
❑ Liver, Hepatitis or pancreatic disease.	❑ Post nasal drip	❑ Tremors
❑ Thyroid problems	❑ Cough/sputum production	❑ Memory Loss
❑ Diabetes	❑ Constipation or Diarrhea	❑ Frequent falls
❑ Arthritis, joint or back pain	❑ Bloody/tarry stools	❑ Anxiety
❑ Stroke (What weakness do you have from the stroke?? ______________________	❑ Abdominal pain	❑ Depression
❑ Recent vision changes	❑ Vomiting	❑ Snoring at night
❑ Difficulty reading	❑ Pain with swallowing	❑ Daytime sleepiness
❑ Recent weight gain/loss	❑ Choking with swallowing	❑ Hearing problems:
❑ Burning/stinging on urination	❑ Food gets stuck in your throat	❑ Other problems: ______________________
❑ Difficulty controlling urine	❑ Difficulty controlling urine	
❑ Constipation, Diarrhea or bloody stools.	❑ Blood in urine	
❑ Limited fluid intake	❑ Abnormal frequency of urination	
❑ Abdominal pain	❑ Voiding small volume of urine	
❑ History of cancer Type: ____________________ Type: ____________________	❑ Pain with urination	
❑ Allergies to drugs	❑ Drenching night sweats	
	❑ Back pain	
	❑ Swelling/fluid of legs	
	❑ Swelling, redness, heat in one or more joints	

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

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   ❑ Been tested for Aids   ❑ Have sleep problems
❑ Have history of depression   ❑ Drink excessive amounts of Caffeine
❑ Any religious or social beliefs that will affect your care:____
❑ Education level:__________________________

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:
	Shingles: ❑ No ❑ Yes Date:
	Tetanus: ❑ No ❑ Yes Date:
Living Will? ❑ Yes ❑ No	Other:

Patient Name: ____ Date of Birth: ___________________________