Today's Date _____ Patient Name _____ Age _____

Birthdate _____ Doctor _____ Height/Weight:_____

Previous Dermatologist/ENT_____

Pharmacy/Location: _____ Durable Medical Equipment Co _____

Health History

Past Medical/Surgical history Have you had? (mark box ☒)	**Review of Systems** Do you have? (mark box ☒)	
❑ Heart Trouble ❑ MI/Heart Attack ❑ Blood pressure problems ❑ Asthma ❑ Bronchitis, emphysema ❑ Thyroid problems ❑ Diabetes ❑ Stroke (What weakness do You have from the stroke?? _____ ❑ Kidney problems ❑ Alzheimer's, other brain disease ❑ History of cancer Type: _____ Type: _____ ❑ HIV positive or AIDS ❑ Other:	❑ Chest pain ❑ Palpitations ❑ Shortness of breath ❑ Fever, chills ❑ Head/Neck Swelling ❑ Seasonal allergies ❑ Hearing problems: ❑ Dizziness/Vertigo ❑ Earache or ear discharge ❑ Sore throat or oral lesions ❑ Stuffy nose or post nasal drip ❑ Cough/sputum production ❑ Sleep Apnea/Snoring ❑ CPAP ❑ Heartburn ❑ Headache ❑ Itchy Ears ❑ Ear Wax ❑ Recurrent throat infections ❑ Other problems: _____ _____	❑ Basal Cell Cancer ❑ Squamous Cell Cancer ❑ Melanoma ❑ Recurrent infections ❑ Anemia ❑ Swelling of legs ❑ Stomach pain ❑ Seizures ❑ Tremors ❑ Frequent falls ❑ Past Cosmetic Procedures _____ ❑ Ringing or buzzing in ears ❑ Speech Language Delay ❑ Noise Exposure ❑ Do you wear Hearing Aids

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

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

Beebe Healthcare Medical Group

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 ❑ None	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	

Patient Name: _____ Date of Birth: _____