Beebe Healthcare Medical Group

Today's Date _____ Patient Name _____ Age _____

Birthdate _____ Date of last physical exam _____ Doctor _____

Pharmacy: _____ Durable Medical Equipment Co _____

Specialists _____

Health History

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

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

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: _____