Patient History
Beebe Family Practice

Name:______________________

DOB:_______________________

Have you had: (Circle Yes or No)

- Heart Trouble? Yes No
- MI/Heart Attack? Yes No
- Angina/Chest pain w/ exertion? Yes No
- Shortness of Breath? Yes No
- Blood pressure problems? Yes No
- Diabetes? Yes No
- Recent Cold? Yes No
- Asthma? Yes No
- Bronchitis, Emphysema, TB or other lung diseases? Yes No
- Seizure disorder/fainting? Yes No
- Hepatitis, liver, pancreas disease? Yes No
- Thyroid problems? Yes No
- Arthritis, joint or back pain? Yes No
- Sickle cell trait or disease? Yes No
- Blood Vessel disease? (Phlebitis, blood clots) Yes No
- Stroke? Yes No
- Recent vision changes? Yes No
- Difficulty reading? Yes No
- Recent weight gain/loss? Yes No
- Burning/stinging on urination? Yes No
- Urgency/difficulty controlling urine? Yes No
- Urinate at night? Yes No
- Change in stools? Yes No
- Constipation/diarrhea? Yes No
- Bloody/tarry stools? Yes No
- When was your last bowel movement?
  -
- Is your fluid intake limited? Yes No
- Are you on a special diet? Yes No
  - Type:
- Stomach pain? Yes No
- History of cancer? Yes No

Date:________________________

- Allergies to drugs? Yes No
- Other allergies? Yes No

If you answered "Yes" to any of these questions, please provide details:

#______________________________________

#______________________________________

#______________________________________

#______________________________________

#______________________________________

List previous biopsies, endoscopies, and surgeries you have had:

1:______________________________________

2:______________________________________

3:______________________________________

4:______________________________________

5:______________________________________

6:______________________________________

7:______________________________________

8:______________________________________

Any abnormal reaction to anesthesia? Yes No

Previous hospitalizations: (for anything other than surgery) GIVE DATE AND REASON:

1:______________________________________

2:______________________________________

3:______________________________________

4:______________________________________

5:______________________________________

6:______________________________________

7:______________________________________

Do you have a living will? Yes No

Have you ever had the measles? Yes No

If no, have you received the measles vaccine? Yes No

If no, have you ever received the Mumps vaccine? Yes No

Have you ever had the chicken pox? Yes No

If no, have you ever recived the chicken pox vaccine? Yes No

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Date of last tetanus shot: ______________

List medications you are presently taking. Include nonprescription and over the counter medications:
(attach additional sheets if necessary)

Name of Med Strength #Doses/day

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Social History:
Do you:

- Presently use tobacco? Yes No
  - How many packs a day?_________
  - How many years?______________
  - When did you quit?____________
- Drink alcohol? Yes No
- Use drugs recreationally? Yes No
- Have sleep problems? Yes No
- History of depression? Yes No
- Have you been tested for AIDS? Yes No
- Are you a minor?
  - Parent/guardian:_______________
  - Phone#:______________________
- Do you have any religious beliefs that will affect your care? Yes No
- Education level:_______________________
- Any difficulty reading? Yes No

If you answered Yes to any of the social history questions, please provide detail below:

Family History:

Relative:	Age (If living)	Medical problems/conditions	Age/Year of Death	Cause of Death
Mother				
Father				
Brother				
Sister				
Children				

Signature:___________________________________ Date:___________________________________