Beebe Family Practice – Millville
32550 Doc's Place, Unit 2, Millville, DE 19967
Phone: 302-539-4302 Fax: 302-539-4305

Today's Date _____ Patient Name _____ Date of Birth: _____
Previous PCP: _____Date of Last Physical Exam _____

Durable Medical Equipment?: _____DME Company: _____

Specialists: _____

Personal Medical Health History

Conditions: Please check conditions you currently have or have had in the past:

- □ Recent Colonoscopy
- □ Recent PSA? Normal or Abnormal?
- □ Abnormal Liver Enzymes
- □ Abnormal Pap Smears
- □ Alcoholism
- □ Allergies
- □ Anemia
- □ Angina / Chest Pain
- □ Anxiety Disorder
- □ Aortic Aneurysm
- □ Appendicitis
- □ Arthritis / Joint Pain _____
- □ Artificial Jnt/Prosthesis _____
- □ Asthma
- □ Atrial Fibrillation
- □ Back Problems
- □ Balance Problems
- □ Bedwetting
- □ Bladder or Kidney Problems
- □ Bleeding/Clotting Disorders
- □ Blood Disorders
- □ Bloody/Tarry Stools
- □ Bone Infection
- □ Bowel/Stomach Problems
- □ Bronchitis, Chronic
- □ Cancer / Personal History:
  CA Type: _____
  CA Type: _____
  CA Type: _____
- □ Cataracts
- □ Celiac Disease
- □ Cholecystitis
- □ Crohn's Disease
- □ Chronic Kidney Disease
- □ COPD
- □ Cystic Fibrosis
- □ Deep Vein Thrombosis
- □ Dentures
- □ Depression
- □ Developmental Delay
- □ Diabetes Type I
- □ Diabetes Type II
- □ Dialysis
- □ Dysphagia
- □ Ear Infections, Chronic
- □ Emphysema
- □ Epilepsy
- □ Fibromyalgia
- □ GERD/Reflux
- □ Glaucoma
- □ Gout
- □ Hearing Loss
- □ Heart Attach (MI)
- □ Heart Disease
- □ Hepatitis? Type: _____
- □ Hernia
- □ HIV Positive or AIDS
- □ Hodgkin's Lymphoma
- □ Hyperlipidemia
- □ Hypertension
- □ Hypothyroidism
- □ Hysterectomy
- □ Kidney Disease
- □ Leukemia
- □ Lupus
- □ Pacemaker (Date: _____)
- □ Pneumonia
- □ Prostate Problems
- □ Rheumatoid Arthritis
- □ Sleep Disorder
- □ Stroke / TIA (Weakness?)
- □ Urinary Incontinence
- □ OTHER: _____
- □ _____
- □ _____
- □ _____

List Previous Surgeries including Biopsies and Endoscopies (Type and Date)		
1.		
2.		
3.		
4.		
5.		
6.		
Date of Last Screenings:		
Pap:	Mammogram:	Bone Density:
PSA:	Colonoscopy:	Complete Bloodwork:
Occupation (if retired, occupation before retirement):		
Education Level:		Difficulty Reading? ❑ Yes ❑ No

Please see other side →

Patient Name _____ Date of Birth: _____

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/Living	Age/Year of Death	Chronic Illness	Cause of Death
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Mother				
Father				
Sister(s)				
Brother(s)				
Children				

Current Medications (including over-the-counter)

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:
❑ No Known Allergies	Tetanus: ❑ No ❑ Yes Date:
	Other:
Living Will? ❑ Yes ❑ No	

Patient Signature: _____ Today's Date: _____