

BEEBE MEDICAL GROUP

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

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

