BEEBE MEDICAL GROUP INFECTIOUS DISEASE

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 ☒)	**Review of Systems** Do you have? (mark box ☒)	
❑ High blood pressure	❑ Chest pain	❑ Drenching night sweats
❑ MI/Heart Attack	❑ Headaches	❑ Palpitations
❑ Diabetes	❑ Shortness of breath	❑ Fluid swelling in legs
❑ High Cholesterol	❑ Unintentional weight loss	❑ Pain with swallowing
❑ Anxiety	❑ Fever > 100°	❑ Choking with swallowing
❑ Depression	❑ Jaw cramping with chewing	❑ Food gets stuck in throat
❑ Carotid surgery	❑ Blurred or double vision	❑ Vomiting
❑ Bypass surgery on legs	❑ Tongue cramping	❑ Abdominal pain
❑ Amputation	❑ Post nasal drip	❑ Constipation
❑ Foot ulcers/Foot infections	❑ Sinus pain	❑ Diarrhea
❑ Neuropathy	❑ Tooth pain	❑ Bloody, black or tarry stools
❑ Immune deficiency	❑ Swollen lymph nodes	❑ Abnormal frequency of urine
❑ Any illness requiring Prednisone or other immune suppressant medication.	❑ Bloody/tarry stools	❑ Voiding small volume of urine
	❑ Cough	❑ Pain with urination
	❑ Sputum production	❑ Back pain
❑ Organ transplantation	❑ Coughing blood	❑ Swelling, redness or heat in One or more joints.
❑ Rheumatoid arthritis, Sarcoidosis, Psoriatic arthritis, Lupus, other rheumatologic disease.	❑ Shortness of breath	
	❑ Shortness of breath lying flat	❑ Skin rash
❑ Crohn's Disease/Ulcerative Colitis	❑ Awakening with shortness of breath	❑ Other problems:
❑ Celiac Disease	❑ Shortness of breath with exertion	_____
❑ Kidney Disease		_____
❑ Dialysis		
❑ Kidney Stones		
❑ Asthma COPD, Emphysema		
❑ Bronchiectasis		
❑ Other:		

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
❑ Pets? (list)	❑ Contact with non-pet animals?	
❑ Travel out of the country: Ever -- YES NO In past 6 month -- YES ❑ Eat/Drink: Raw meats/eggs/fish/unpasteurized milk (please circle)		

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	# of times per day

Medication Allergies	Vaccines
Include Drug Name and Reaction	Flu: ❑ No ❑ Yes Date:
	Pneumonia: ❑ No ❑ Yes Date:
	Shingles: ❑ No ❑ Yes Date:
	Tetanus: ❑ No ❑ Yes Date:
	Other:
Living Will? ❑ Yes ❑ No	

Patient Name: _____ Date of Birth: _____