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

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

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 ❑ Been tested for Aids ❑ Have sleep problems
❑ Have history of depression ❑ Drink excessive amounts of Caffeine
❑ Any religious or social beliefs that will affect your care:_____
❑ Education level:_____

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	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	Other:

Patient Name: _____ Date of Birth: _____