|

Patient Name: ______________________________

Date: __________ **DOB:** __________ **Gender: M / F**

Beacon Internal Medicine
Medical/Personal History

****Please answer every question on both sides of this form****

Please check conditions, which you have had in the past:

CVS
- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ Congestive Heart Failure
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Angina
- ○ Frequent Chest Pain
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

Lymphatic / Hematologic
- ○ Diabetes Mellitus
- ○ Overactive Thyroid
- ○ Underactive Thyroid
- ○ Anemia
- ○ Thyroid Goiter
- ○ Blood Transfusion

Skin / Breast
- ○ Acne
- ○ Eczema / Psoriasis
- ○ Fibrocystic Breast Disease
- ○ Abnormal Mammogram
- ○ Rashes
- ○ Hives
- ○ Moles

Respiratory
- ○ Sleep Apnea
- ○ Frequent Bronchitis
- ○ Emphysema
- ○ Pneumonia
- ○ Asthma
- ○ Clots in Lungs
- ○ Tuberculosis

Musculoskeletal / Extremities
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Joint Pain
- ○ Gout
- ○ Broken Bones
- ○ Osteoporosis
- ○ Osteopenia
- ○ Fibromyalgia
- ○ Neck Pain (hern. disc)
- ○ Back Pain (herniated disc)

HEENT
- ○ Glasses / Contacts
- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Loss
- ○ Frequent Ear Infections
- ○ Ringing in Ears
- ○ Allergies
- ○ Frequent Sinus Infections
- ○ Mouth Sores

Neurologic / Psychiatric
- ○ Seizure
- ○ TIA
- ○ Stroke
- ○ Numbness
- ○ Weakness
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Suicide Attempt
- ○ Physical Abuse
- ○ Sexual Abuse
- ○ Mental Illness
- ○ Dizziness
- ○ Vertigo
- ○ Peripheral Nerve Disease
- ○ Insomnia

General
- ○ Abnormal Weight Loss
- ○ Abnormal Weight Gain
- ○ Cancer/Tumor ________

____

_______# of Pregnancies

_______ Live Births

_______ Miscarriages

_______ Abortions

GI /GU
- ○ Heartburn
- ○ Stomach Ulcers
- ○ Gallstones
- ○ Blood in Stool
- ○ Hepatitis
- ○ Diarrhea / Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain
- ○ Colon Polyps
- ○ Urinary Frequency
- ○ Bladder Infections
- ○ Prostate Disease
- ○ Urinary Incontinence
- ○ Kidney Stones
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Cirrhosis of the Liver
- ○ Liver Failure
- ○ Pancreatitis
- ○ Endometriosis
- ○ Abnormal PAP
- ○ Sex Transmitted Infection
- ○ HIV Infection

Provider Notes: ____

____

Please list any allergies or intolerance to drugs or other substances: ______________________

____

____

Please list the medications currently taken, their dosages, and how many times per day you take them:

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

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Please indicate any surgeries you have had and the year you had them:

○ Angioplasty ___________ ○ Trauma Related _______ ○ Stomach _____________ ○ Tubal Ligation _________
○ Carotid Artery _________ ○ Back/neck ____________ ○ Inguinal Hernia ________ ○ C-Section ____________
○ Other Vascular ________ ○ Hip _________________ ○ Colonoscopy __________ ○ Hysterectomy _________
○ Coronary Bypass ______ ○ Knee ________________ ○ Gallbladder ___________ ○ Ovary Removed _______
○ Chest/Lung ___________ ○ Carpal Tunnel _________ ○ Appendectomy ________ ○ Breast _______________
○ Tonsillectomy _________ ○ Sinus ______________ ○ Prostate _____________ ○ Thyroid ______________
○ Neurosurgery _________ ○ Ear_________________ ○ Bladder ______________ ○ Other _______________

Provider Notes: ____

Please indicate when you last had any of the following preventative tests or services:

○ Cardiac Angiogram _____ ○ Flu Vaccine ____________ ○ PSA Blood Test _________ ○ Colonoscopy __________
○ Stress Test ____________ ○ Pneumonia Vaccine ____ ○ Rectal Exam ___________ ○ Mammo/Breast Exam ___
○ EKG ________________ ○ Tetanus Vaccine _______ ○ Colon Cancer Stool Test __ ○ PAP Smear ___________
○ Chest X-Ray __________ ○ Hepatitis Vaccine ______ ○ Flexible Sigmoidoscopy ___ ○ Last Menstrual Period ___
○ Echocardiogram _______ ○ Bone Density Test _____ ○ Barium Enema __________ ○ Other _______________

Provider Notes: ____

Family Medical History

Please check major illness in your family members (mother, father, brother, sister, or children)

○ Tuberculosis ○ Diabetes Mellitus ○ Kidney Disease ○ Breast Cancer
○ Emphysema ○ Thyroid Disease ○ Epilepsy ○ Ovarian Cancer
○ Heart Disease ○ Anemia ○ Neurologic Disorder ○ Colon Cancer
○ High Blood Pressure ○ Hemophilia ○ Liver Disease ○ Prostate Cancer
○ Osteoporosis ○ High Cholesterol ○ Hepatitis ○ Skin Cancer

Provider Notes: ____

Personal Information

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

What is or was your occupation? ____

Who is currently living in your home? ____

Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home? _______

Risk Reduction:

Are you sexually active? ○ Not Active ○ Heterosexual ○ Homosexual ○ Bisexual

Do you or your partner use condoms (practice safe sex)? ○ Always ○ Never ○ Sometimes

Do you use tobacco products? ___________If so, how much: _______________________________

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc.)? _______________

How much alcohol do you consume weekly? ○ None ○ 0 – 5 ○ 6 – 12 ○ >12

Please indicate any of the following behaviors you follow:

○ Wear seatbelt ○ Wear helmet with bike / motorcycle ○ Gun in house ○ Gun secured

○ Fire extinguisher in house ○ Perform self breast ○ Perform self testicular exam ○ Smoke detector in house

What are your current dietary patterns? ____

Exercise on regular basis? ____

Patient Signature: __________________________ Provider Signature: ____________________ MD/DO/PA-C