

Patient Name: _____

**Beacon Internal Medicine
Medical/Personal History**

Date: _____ DOB: _____ Gender: M / F

******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:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

- Angioplasty _____
- Carotid Artery _____
- Other Vascular _____
- Coronary Bypass _____
- Chest/Lung _____
- Tonsillectomy _____
- Neurosurgery _____
- Trauma Related _____
- Back/neck _____
- Hip _____
- Knee _____
- Carpal Tunnel _____
- Sinus _____
- Ear _____
- Stomach _____
- Inguinal Hernia _____
- Colonoscopy _____
- Gallbladder _____
- Appendectomy _____
- Prostate _____
- Bladder _____
- Tubal Ligation _____
- C-Section _____
- Hysterectomy _____
- Ovary Removed _____
- Breast _____
- Thyroid _____
- Other _____

Provider Notes: _____

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

- Cardiac Angiogram _____
- Stress Test _____
- EKG _____
- Chest X-Ray _____
- Echocardiogram _____
- Flu Vaccine _____
- Pneumonia Vaccine _____
- Tetanus Vaccine _____
- Hepatitis Vaccine _____
- Bone Density Test _____
- PSA Blood Test _____
- Rectal Exam _____
- Colon Cancer Stool Test _____
- Flexible Sigmoidoscopy _____
- Barium Enema _____
- Colonoscopy _____
- Mammo/Breast Exam _____
- PAP Smear _____
- Last Menstrual Period _____
- Other _____

Provider Notes: _____

Family Medical History

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

- Tuberculosis
- Emphysema
- Heart Disease
- High Blood Pressure
- Osteoporosis
- Diabetes Mellitus
- Thyroid Disease
- Anemia
- Hemophilia
- High Cholesterol
- Kidney Disease
- Epilepsy
- Neurologic Disorder
- Liver Disease
- Hepatitis
- Breast Cancer
- Ovarian Cancer
- Colon Cancer
- Prostate Cancer
- 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
- Fire extinguisher in house
- Perform self breast
- Perform self testicular exam
- Smoke detector in house
- Wear helmet with bike / motorcycle
- Gun in house
- Gun secured

What are your current dietary patterns? _____

Exercise on regular basis? _____

Patient Signature: _____ **Provider Signature:** _____ **MD/DO/PA-C**