**BECKHAM INTERNAL MEDICINE**

**Patient's Legal Name:** ___________________________________ **Preferred Name:** ______________________

**Date of Birth:** ________________________ **Gender:** _______________________________

**Reason for today's visit:**
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**Current Medications** (use back of page if necessary):

| Name | Strength | How Often It's Taken | Prescribed By |
| --- | --- | --- | --- |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

**Allergies** (use back of page if necessary):

| Name of Medication/Food | Reaction (hives, nausea, etc…) |
| --- | --- |
| 1. | |
| 2. | |
| 3. | |

**Past Medical History:** Please check if you have had or are currently diagnosed with the following medical conditions.

| | | |
| --- | --- | --- |
| _____ Measles | _____ COPD | _____ Migraines |
| _____ Chicken Pox | _____ Osteoarthritis | _____ Seizure Disorder |
| _____ Mumps | _____ Gout | _____ Parkinsons Disease |
| _____ Scarlet Fever | _____ Rheumatoid Arthritis | _____ Alzheimer's |
| _____ Rheumatic Fever | _____ Autoimmune Disease | _____ Breast Cancer |
| _____ Anxiety | _____ High Blood Pressure | _____ Colon Cancer |
| _____ Depression | _____ High Cholesterol | _____ Skin Cancer |
| _____ Other Mental Illness | _____ Heart Murmur | _____ Cervical Cancer |
| _____ Hay Fever/Seasonal Allergies | _____ Diabetes | _____ Crohn's Disease |
| _____ Asthma | _____ Thyroid problems | _____ Ulcerative Colitis |

**Patient Name:** ___________________________ **Page 2**

Past Medical History continued….Please list any other chronic illness(es) that you have been diagnosed with, that were not mentioned above_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Have you ever had a blood transfusion? __________

**Past Surgical History** (use back of page if necessary):

Procedure Approximate Date Procedure Approximate Date

1.______________________________________________________________________________
2.______________________________________________________________________________
3.______________________________________________________________________________
4.______________________________________________________________________________
5.______________________________________________________________________________
6.______________________________________________________________________________

**Past Hospitalizations** (use back if necessary):

Reason Approximate Date Reason Approximate Date

1.______________________________________________________________________________
2.______________________________________________________________________________

**For Women Only:**

How many pregnancies have you had? _____

How many deliveries have you had? _____

Have you had a hysterectomy (to remove your uterus)? _____

Have you had your ovaries removed? _____

Date of last pap smear. ____________________

Where was this done? _________________

Date of last mammogram. ____________________

Where was this done? _________________

First day of last period. ____________________

**Preventive Care Maintenance (for everyone):**

Date of last flu vaccination: __________

Date of last tetanus injection: __________

Date of shingles vaccination: __________

Date of pneumonia vaccination: __________

Have you had the Hepatitis B vaccination series? __________

Have you had the Hepatitis A vaccination series? __________

Last Physical Exam: ________________ Where: ____________________

Last Eye exam: ____________________ Where: ____________________

Bone Density: _____________________ Where: ____________________

Last Colonoscopy: __________________ Where: ____________________

Last Spirometry: ____________________ Where: ____________________

**Patient Name: ___________________________** 

**Family History:**

Are you adopted? __________

| | Alive or deceased | Cause of death, if known | Current age/ Age at death | Chronic medical illnesses (example: high blood pressure, diabetes, heart attack, breast cancer.) If known, list age of cancer diagnoses or heart attacks. Write unknown if you do not know a member's health history. |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Brother(s) | | | | |
| Sister(s) | | | | |
| Maternal GM | | | | |
| Maternal GF | | | | |
| Paternal GM | | | | |
| Paternal GF | | | | |
| Children | | | | |

**Social History:**

Marital Status: _________________ Occupation: ___________________________ Retired? __________

Education (highest level attained): _____________________

Tobacco Use:

Do you *currently* use tobacco products? ________ Which products do you use? _________________

Have you used tobacco products in the past? _______ When did you quit? _____________________

If you are a current user…

How much of the tobacco product do you use? _____________________

How old were you when you started using tobacco products? _____________________

Are you interested in quitting tobacco? _____________________

Alcohol Use:

How many glasses of alcohol do you drink per day? _______ per week? _______

Do you drink alcohol less than 4x/year? _____

Which type of alcohol do you usually drink (liquor, beer, wine, etc…)? _______________

If you drink more than 4 times in one year…

Have you ever the need to cut down on how much alcohol you drink? __________

Have you ever been annoyed when someone has talked to you about your drinking? __________

Have you ever felt guilty about how much you drink? __________

Have you ever needed an "eye opener" in the morning to get you started? __________

Drug Use:

Do you *currently* use any illegal drugs? __________ If yes, which one(s)? ____________________

Any IV drug use? __________

Caffeine Use:

How much caffeine to you drink a day? _______ What types of caffeine? ____________________

Exercise:

Do you get regular exercise? __________

If so, how many days a week do you exercise? __________

What kind of exercise(s) do you regularly perform? ________________________________________

____________________________________________ ______________________________________

Patient Signature Date