

Name: _____

Beacon Family Practice – Health History

Date: _____

Have YOU had? (Please circle Y or N Answer)

- 1. Heart trouble Y N
- Heart attack (MI) Y N
- Angina/chest pain with exertion Y N
- Shortness of breath Y N
- 2. Blood pressure problems Y N
- 3. Diabetes Y N
- 4. Asthma Y N
- 5. Bronchitis, Emphysema, or other lung disease Y N
- 6. Seizure disorder/fainting Y N
- 7. Hepatitis, liver, pancreas disease Y N
- 8. Thyroid problems Y N
- 9. Arthritis, joint, back pain Y N
- 10. Sickle Cell trait or disease Y N
- 11. Phlebitis or blood clots Y N
- 12. Stroke Y N

What deficits/weakness do you have?

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- 13. Bleeding problems Y N
 - 14. Vision Problems Y N
 - 15. Hearing Problems Y N
 - 16. Recent weight gain or loss Y N
 - 17. Urination at night Y N
 - 18. Urgency/difficulty leaking urine Y N
 - 19. Constipation/diarrhea Y N
 - 20. Bloody/tarry stools Y N
 - 21. Is your fluid intake limited? Y N
 - 22. Are you on a special diet? Y N
 - 23. Stomach pains Y N
 - 24. History of Cancer Y N
 - 25. Allergies to drugs Y N
 - 26. Other allergies Y N
 - 27. Ever had a blood transfusion Y N

OBGYN History

- 1. # times pregnant _____ Abortions _____
miscarriages _____
- 2. # of children _____
- 3. Age periods started _____ Age they stopped _____
- 4. Currently on Birth control Y N
Method _____

If you answered "Y" to any question on this page, please provide more details here or on the bottom of Pg 2.

- # _____
- # _____
- # _____
- # _____
- # _____
- # _____

Please list previous biopsies, endoscopies, and surgeries you had either hospitalized or as an outpatient.

Type and Date:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____

Previous Hospitalizations other than above:

List date and reasons

- 1. _____
- 2. _____
- 3. _____
- 4. _____

List medications you are presently taking. Include non-prescription and over the counter pills, herbals, vitamins. Please include the Dosage and frequency of each pill.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

