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

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: _____

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