Premier Health
Premier HealthNet

Beavercreek Family Medicine
Established Patient Medical History

Patient Name/Birthdate _____

Current concerns: _____

_____

_____

Changes in Family History since your last physical? ☐ No If yes, please list

_____

_____

_____

New procedures/diagnosis since your last physical? ☐ No If yes, please list

_____

_____

_____

Review of systems - Excluding episodic illnesses such a colds, please check if you have been experiencing the following symptoms or check (-) if all negative

ROS	(-)	Please check any CURRENT positive symptoms or check ALL NEGATIVE (-) column
Constitutional		☐ Unintentional weight loss ☐ Fever ☐ Chills ☐ Poor appetite ☐ Unusual fatigue
Eyes		☐ Eye pain ☐ Discharge ☐ Redness ☐ Decrease in vision ☐ Double vision
ENT		☐ Sore throat ☐ Ear pain ☐ Hearing loss ☐ Nosebleeds ☐ Ringing in ears ☐ Sinus congestion
Cardiovascular		☐ Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart Murmur ☐ Swelling in feet or ankles
Respiratory		☐ Shortness of breath ☐ New cough ☐ Chronic cough ☐ Coughing up blood ☐ coughing up sputum
Gastrointestinal		☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Difficulty swallowing
Genitourinary (male)		☐ Painful urination ☐ Slow Stream ☐ Frequent Urination ☐ Penile discharge ☐ Blood in urine ☐ Incontinence
Genitourinary (female)		Last Menstrual period date _____ ☐ Menopausal ☐ Painful urination ☐ Frequent Urination ☐ Blood in urine ☐ Incontinence ☐ Irregular periods ☐ Painful periods ☐ Vaginal discharge ☐ Pain with intercourse
Skin		☐ Rash ☐ Hives ☐ Moles changes ☐ Skin sores or ulcers
Musculoskeletal		☐ Joint redness ☐ Joint swelling ☐ Muscles aches Pain in following ☐ Shoulders ☐ Hands ☐ Hips ☐ Knees ☐ Ankles ☐ Feet
Psychiatric		☐ Anxiety ☐ Depression ☐ Suicidal thoughts ☐ Panic attacks ☐ Controlled with medication ☐ Not controlled with medication ☐ Alcohol dependence ☐ Drug dependence
Endocrine		☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst
Neurological		☐ Unusual headache ☐ Chronic unchanged headaches ☐ Numbness ☐ Weakness ☐ Lightheadedness ☐ Vertigo ☐ Fainting
Hematologic		☐ Unusual bruising ☐ Bleeding ☐ Enlarged glands/lymph nodes
Please comment on positives		

Social history

( ) Non-smoker (never smoked) ( ) Ex-smoker ( ) Current Smoker ____ Packs per day

Alcohol consumption ( ) never ( ) occasional ( ) frequent

Recreational drugs ( ) never ( ) occasional ( ) frequent Type _____

(This may or may not become part of your permanent medical record. Information may be either transferred to progress note or may be scanned)