BETHESDA HEALTH
BETHESDA HEALTH PHYSICIAN GROUP

PATIENT INFORMATION

Name: ____ Sex: M F

Preferred Name/Nickname: ________________________

SSN: ________________ Date of Birth: _____________

Race: ________________ Ethnicity: _______ Primary Language: _________

Local Address: ____

____

Local Phone: ________________ Cell Phone: ______________________

Emergency Contact: ____

Relationship: _______________ Phone:_____________________

How did you find our practice? ____

Preferred Pharmacy: _______________________ Phone: _____________

Do you have a living will or DNR form: ____________ (We have free forms if needed)

SEASONAL PATIENTS

Out-of-town Address: ____

____

Out-of-town Phone: _____________

Who is your usual primary care physician?

Name: ____

Phone: ____________________ Fax: ______________________

Address: ____

____

When do you come to South Florida? ____________ Leave? ____________

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Berry Pierre, D.O.,M.P.H.

Today's Date:

ADULT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PERSONAL HEALTH HISTORY

Check any medical problems *that other doctors have diagnosed in the past*

Heart & Blood Vessels
- ○ High Cholesterol
- ○ Congestive Heart Failure
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ Heart Valve Disease
- ○ Blood Clots in Veins
- ○ Blocked Arteries in Neck
- ○ Blocked Arteries in Legs

Skin
- ○ Acne
- ○ Eczema
- ○ Psoriasis

Lungs
- ○ Sleep Apnea
- ○ COPD
- ○ Emphysema
- ○ Asthma
- ○ Clots in Lungs

Blood
- ○ Anemia
- ○ Blood Transfusion
- ○ Leukemia
- ○ Lymphoma
- ○ Blood Clots

Do you currently use or have ever used tobacco?

____

Do you currently use or have ever used alcohol?

____

Do you currently use or have ever used illicit drugs?

____

Metabolism/Endocrine
- ○ Diabetes Mellitus
- ○ Thyroid Disease
- ○ Gout
- ○ Vitamin D Deficiency

Abdomen & Pelvis
- ○ Heartburn
- ○ Stomach Ulcers
- ○ Blood in Stool
- ○ Diarrhea
- ○ Constipation
- ○ Hemorrhoids
- ○ Colon Polyps
- ○ Enlarged Prostate
- ○ Kidney Failure
- ○ Ulcerative Colitis
- ○ Crohn's Disease
- ○ Diverticulitis/Diverticulosis
- ○ Irritable Bowel Disease
- ○ Liver Failure
- ○ Pancreatitis

Women's Health
- ○ Fibrocystic Breast Disease
- ○ Abnormal Mammogram
- ○ Endometriosis
- ○ Abnormal PAP smear

Cancer
- ○ Prostate
- ○ Lung
- ○ Breast
- ○ Colon
- ○ Cervical
- ○ Skin

Muscles & Bones
- ○ Rheumatoid (autoimmune) Arthritis
- ○ Osteoarthritis ("wear and tear")
- ○ Osteoporosis
- ○ Fibromyalgia
- ○ Neck Pain
- ○ Back Pain

Eyes, Ears, Nose & Mouth
- ○ Glaucoma
- ○ Cataracts
- ○ Hearing Problems

Brain & Nerves
- ○ Seizures
- ○ TIA ("Mini-stroke")
- ○ Stroke
- ○ Neuropathy ("nerve damage")
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Vertigo

Psychiatry
- ○ Panic Attacks
- ○ Depression
- ○ Anxiety
- ○ Suicide Attempt
- ○ Vertigo
- ○ Tobacco/Alcohol Abuse

Infection
- ○ Hepatitis
- ○ HIV
- ○ Sexually Transmitted Diseases
- ○ Tuberculosis

Other diagnoses not listed:

____

____

Immunizations and (approximate) dates:	☐ Tetanus	☐ Pneumonia
	☐ Influenza	☐ Chickenpox/Shingles

Surgeries/ Procedures (Colonoscopy, Mammogram, EGD, etc)		
Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

Please check and indicate age at onset where appropriate

	Heart Attack	Stroke	Hypertension	Diabetes	Colon Cancer	Lung Cancer	Breast Cancer	Prostate Cancer
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	
Siblings	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐
Grandfathers		☐	☐	☐	☐	☐	☐	☐
Grandmothers		☐	☐	☐	☐	☐	☐	
Uncles		☐	☐	☐	☐	☐	☐	☐
Aunts		☐	☐	☐	☐	☐	☐	

Are there any other diseases with which more than one family member has been diagnosed? ______________________________

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