BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

PATIENT HEALTH INFORMATION

(PLEASE USE BLUE OR BLACK INK)

DOCTOR:_____ **TODAY'S DATE:** _____

NAME:_____ **DATE OF BIRTH**_____

SOCIAL SECURITY # _____

ADDRESS: _____

_____

HOME PHONE: _____ **CELL:** _____

MARITAL STATUS :(CIRCLE) **SINGLE** **MARRIED** **WIDOWED** **DIVORCED**

EMPLOYER: _____ **PHONE:** _____

SPOUSE EMPLOYER _____ **PHONE:** _____

NEAREST RELATIVE: _____ **PHONE:** _____

RELATIONSHIP: _____

PRESENT ILLNESS: List your primary ailments as of today and how long you have had them.

(1)_____

(2)_____

(3)_____

(List other ailments on back of page)

PAST HISTORY: List below all serious illnesses and injuries and or operations

(1)_____

(2)_____

(3)_____

(List other ailments on back of page)

ALLERGIES AND REACTIONS: _____

List all medications including vitamins/herbal supplements;

_____

_____

_____

_____

YOUR NAME _____

Circle YES or NO to the following questions.

EAR, NOSE & THROAT:

Do you have any type of eye disease?	**YES**	**NO**
Do you have any type of ear disease?	**YES**	**NO**
Do you have any type of hay fever or sinus trouble?	**YES**	**NO**
Do you have frequent sore throats?	**YES**	**NO**

CHEST:

Have you ever had a chronic chest condition? (Such as asthma, bronchitis, etc.?)	**YES**	**NO**
Do you smoke: pack/day _____	**YES**	**NO**

CARDIOVASCULAR:

Has a Dr. ever said that you had heart trouble?	**YES**	**NO**
Has a Dr. ever said that you have high blood Pressure?	**YES**	**NO**
Have you ever had rheumatic fever?	**YES**	**NO**
Do you get tired easily or short of breath?	**YES**	**NO**
Do your ankles swell at times?	**YES**	**NO**

GI:

Do you suffer from upset stomach?	**YES**	**NO**
Has a doctor ever said you had an ulcer?	**YES**	**NO**
Do you drink alcoholic beverages?	**YES**	**NO**
Do you partake in recreational drugs?	**YES**	**NO**
Have your bowel habits changed in the past year?	**YES**	**NO**

GU:

Have you ever had kidney disease or infection?	**YES**	**NO**
Have you had frequent urinary tract infections?	**YES**	**NO**

METABOLIC:

Do you have sugar diabetes?	**YES**	**NO**
Do you seem to have excessive thirst or Excessive urine output?	**YES**	**NO**
Do you have thyroid trouble?	**YES**	**NO**

JOINTS:

Are your joints often painful or swollen?	**YES**	**NO**

NERVES:

Have you ever had a nervous breakdown	**YES**	**NO**
Do you seem to be tense and nervous all the time?	**YES**	**NO**
Have you ever been a patient in a mental health facility	**YES**	**NO**

YOUR NAME:_____

FAMILY HISTORY:

PLEASE CIRCLE THE STATE OF HEALTH ON THE FOLLOWING PEOPLE. IF DECEASED PLEASE GIVE THE CAUSE OF DEATH:

Husband/Wife	**GOOD**	**FAIR**	**POOR**
Deceased/cause of death_____			
Father	**GOOD**	**FAIR**	**POOR**
Deceased/cause of death _____			
Mother	**GOOD**	**FAIR**	**POOR**
Deceased/cause of death _____			
SISTERS	**GOOD**	**FAIR**	**POOR**
Deceased/cause of death_____			
BROTHERS	**GOOD**	**FAIR**	**POOR**
Deceased/cause of death_____			

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES?

SUGAR DIABETES	**YES**	**NO**
T.B. (Tuberculosis)	**YES**	**NO**
HEART TROUBLE	**YES**	**NO**
HIGH BLOOD PRESSURE	**YES**	**NO**
EPILEPSY	**YES**	**NO**
SEVERE RHEUMATISM	**YES**	**NO**
CANCER	**YES**	**NO**

Has anyone in your family ever been a patient in a mental hospital?	**YES**	**NO**
Has anyone in your family ever committed suicide?	**YES**	**NO**

FOR WOMEN ONLY:

How many children do you have? _____ Ages:_____

Have you ever had a miscarriage?	**YES**	**NO**

When was your last menstrual period? _____

Do your periods come at regular intervals?	**YES**	**NO**

When was your last pregnancy? _____

YOUR NAME _____

ADDITIONAL PERTINENT COMMENTS: _____

_____

_____

_____

_____

_____

REFERRED BY: _____

NAME OF PRIMARY INSURANCE: _____

ADDRESS: _____

CERTIFICATE, POLICY OR ID # _____ **GROUP #** _____

NAME OF SECONDARY INSURANCE _____

ADDRESS: _____

CERTIFICATE, POLICY OR ID # _____ **GROUP #** _____

We file primary and secondary insurance for you. We are not able to file a third insurance.

I, the undersigned, certify I have insurance coverage with

_____ **Insurance Company**

Name and assign directly to Beaumont Internal Medicine & Geriatric Assoc all insurance benefits, if any, if otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize Beaumont Internal Medicine & Geriatrics Assoc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Name: _____ **Date:** _____

Co-pays, co-insurance and deductibles are due the day of service.
Please consult our Financial Policies and Practice Policies for further information.