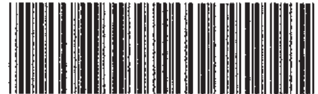
Benefis
HEALTH SYSTEM



OUTPATIENT SUMMARY SHEET

Date: ___________ Name: _______________________ Occupation: ________________________________

Family Doctor: _________________________________

Problems/Symptoms: ____

Length of Time You Have Been Having Symptoms: _________________________ (days, weeks, months, etc.)

Adverse Drug Reactions / Allergies:			Latex Allergies:
			___ Yes ___ No

Current / Long Term Medication Use (Include Over the Counter & Herbal Preparations)		

Please check if you have had any of the following conditions or diagnoses:

_____Bleeding Problems _____Tuberculosis (TB) _____Diabetes _____Ulcers
_____High Blood Pressure _____Asthma _____Depression/Anxiety _____Dizziness
_____Chest Pain _____Headaches _____Blood Clots _____Hepatitis
_____Cancer _____Tingling _____Changes in Vision
_____ Other, Please List: ____

Hospitalizations – Operations – Invasive Procedures – Chronic Conditions			
Procedure/Condition	Date	Procedure/Condition	Date

Do you smoke/use tobacco? _____Yes _____No

If you quit smoking/using tobacco, when did you stop? ___________

Do you use alcohol? _____Yes _____No If yes, how much? ________________

Updated By:

Initials	Date	Initials	Date	Initials	Date
_____	___________	_____	___________	_____	___________
_____	___________	_____	___________	_____	___________
_____	___________	_____	___________	_____	___________