



Name: _____

DOB: _____

Date: _____

MRN#: _____

Thank you for choosing Baylor Scott & White Primary Care.
 We appreciate your assistance by completing this form, as it will help us better care for you.

Were you referred by another physician? If so, who? _____

Reason(s) for your visit today? _____

Allergies - List any significant reactions to food or medications below

Allergic to	Allergic to

Medications - List any medications you take, prescription and other-the-counter along with the doses

Medication	Dose	Refill Needed (Y/N)?

Pharmacy – List your local and mail order pharmacy information

	Name and address	Phone #
Local		
Mail Order		

Your Care Team – List include the names and specialties of all providers you currently see

Provider Name and Specialty	Phone #

Past Medical History – Check all that apply

No medical problems

<input type="checkbox"/>	Abnormal pap smear
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Atrial Fibrillation
<input type="checkbox"/>	Breast Cancer
<input type="checkbox"/>	Cervical Cancer
<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Chronic Back Pain
<input type="checkbox"/>	Colon Cancer
<input type="checkbox"/>	Deep Vein Thrombosis

<input type="checkbox"/>	Depression
<input type="checkbox"/>	GERD/Reflux
<input type="checkbox"/>	Gestational Diabetes
<input type="checkbox"/>	GI Bleed
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Hyperthyroidism

<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	Kidney Stone
<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Kidney Failure
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Skin Cancer
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	Ulcers

Additional history you feel would be valuable for me to be aware of: _____

Past Surgical History – Check all that apply

No medical problems

<input type="checkbox"/>	Abdominal Aneurysm
<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	Back Surgery
<input type="checkbox"/>	Bariatric Surgery
<input type="checkbox"/>	Brain Surgery
<input type="checkbox"/>	Breast Biopsy L/R
<input type="checkbox"/>	Breast Enhancement
<input type="checkbox"/>	Breast Surgery L/R
<input type="checkbox"/>	CABG – Heart Bypass
<input type="checkbox"/>	Cardiac Catheterization
<input type="checkbox"/>	Carotid Endarterectomy
<input type="checkbox"/>	Carpal Tunnel Surgery L/R

<input type="checkbox"/>	Cataract Surgery L/R
<input type="checkbox"/>	Cerebral Aneurysm
<input type="checkbox"/>	Gallbladder Removal
<input type="checkbox"/>	Colon Surgery
<input type="checkbox"/>	Heart Transplant
<input type="checkbox"/>	Hip Surgery R/L/Both
<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Hysterectomy w/ovaries removed
<input type="checkbox"/>	Kidney Removal L/R
<input type="checkbox"/>	Kidney Removal L/R
<input type="checkbox"/>	Kidney Transplant
<input type="checkbox"/>	Knee Arthroscopy
<input type="checkbox"/>	Knee Surgery L/R

<input type="checkbox"/>	Liver Transplant
<input type="checkbox"/>	Lung Transplant
<input type="checkbox"/>	Mastectomy R/L/Both
<input type="checkbox"/>	Neck Surgery
<input type="checkbox"/>	Previous C-Section
<input type="checkbox"/>	Shoulder Surgery R/L
<input type="checkbox"/>	Sinus Surgery
<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Tubal Ligation (tubes tied)
<input type="checkbox"/>	Valve Replacement
<input type="checkbox"/>	Other

Family History – Check all that apply

	None	Alcohol Abuse	Alzheimer's	Asthma	Autoimmune	Breast Cancer	Cancer	Colon Cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease	
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							
Mat GM																							
Mat GF																							
Pat GM																							
Pat GF																							
Other:																							

Social History

Alcohol Use: Yes No

Number of drinks/week: _____ glasses of wine _____ cans of beer _____ shots of liquor

Sexually Active: Yes Not Currently Never

Type of Birth Control: Partners: Female Male Both

Drug Use: Yes No Former Type of Drugs:

Tobacco Use: Yes No

If so, what type: Cigarettes Pipe Cigars Electronic Cigarette Snuff Chew

Year Started: Packs/Day: Quit Date:

Occupation:

Marital Status: Single Married Divorced Widowed

Number of Children:

Year of Education:

Who do you live with?

OB/GYN History

Last Menstrual Period: _____

Duration of Period: _____ Interval between periods: _____ Heavy Periods: Yes No

of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____

Immunizations – Enter the dates of your most recent vaccinations

Influenza (yearly)	_____	Human Papilloma Vaccination (HPV/Gardasil):	_____
Tetanus/TdaP/Td:	_____	Pneumovax:	_____
Shingrix – Dose #1	_____	Prevnar:	_____
Shingrix – Dose #2	_____	Zostavax:	_____

Preventative Care – Enter the dates of your most recent test results.

	Date	Result	Provider/Facility
Colonoscopy			
Sigmoidoscopy			
Cologuard			
Hemoccult			
Osteoporosis/DEXA			
For Women Only			
Pap Smear			
Mammogram			
Breast Exam			
For Men Only			
Last Prostrate Exam			
PSA			

Advanced Directives

Do you have a living will?	Yes	No
Do you have a Medical Power of Attorney?	Yes	No
Do you have an out of hospital “Do Not Resuscitate” (DNR)?	Yes	No
If you answered YES to any of these questions, please bring a copy of the legal document to your first visit.		
If you answered NO , we have information that will be provided for you to discuss with your family so that Advanced Medical Directives can be incorporated into your medical chart.		

Constitutional	Activity Change	Appetite Change	Chills	Chronic Pain	Daytime Sleepiness
	Excessive Sweating	Fatigue	Fever	Unexpected Weight Change	
HENT	Congestion	Dental Problems	Drooling	Ear Pain	Facial Swelling
	Hearing Loss	Mouth Sores	Nosebleeds	Post Nasal Drip	Reflux
	Runny Nose	Sinus Pain	Sinus Pressure	Sneezing	Snoring
	Trouble Swallowing	Voice Change			
Eyes	Discharge	Itching	Pain	Redness	Sensitivity to Light
	Visual Disturbance				
Respiratory	Apnea	Chest Tightness	Choking	Cough	Shortness of Breath
	Voice Change	Wheezing			
Cardiovascular	Chest Pain	Leg Swelling	Palpitations		
GI	Abdominal Bloating	Abdominal Pain	Rectal Bleeding	Blood in Stool	Bowel Incontinence
	Constipation	Diarrhea	Nausea	Rectal Pain	Vomiting
Endocrine	Cold Intolerance	Heat Intolerance	Excessive Thirst	Excessive Appetite	Urinary Frequency
Genital – Urinary	Bladder Incontinence		Breast Lump	Decreased Libido	Difficulty Urinating
	Pain w/intercourse	Painful Urination	Increased Urinary Frequency		Enuresis
	Flank Pain	Frequency	Genital Sores		Hematuria
	Menstrual Changes	Nocturia	Pelvic Pain		Sexual Difficulties
	Urgency	Decreased Urine	Vaginal Bleeding	Vaginal Discharge	Vaginal Pain
Musculoskeletal	Joint Pain	Back Pain	Gait Problems	Joint Swelling	Myalgia's
	Neck Pain	Neck Stiffness			
Skin	Color Change	Hair Change	Hair Loss	Nail Change	Pallor
	Rash	Skin Change			
Allergy	Environmental Allergies		Food	Immunocompromised	
Neurological	Dizziness	Facial Asymmetry	Headaches	Light Headedness	Numbness
	Seizures	Speech Difficulty	Syncope	Tremors	Weakness
Hematological	Lymph Node Swelling		Bruise/Bleed Easily		
Psychiatric	Agitation	Behavior Problem	Confusion	Decreased Concentration	
	Depressed Mood	Dysphoric Mood	Hallucinations	Hyperactive	Nervous/Anxious
	Self-Inquiry	Severe Stress	Sleep Disturbance	Suicidal Ideas	
Mood Screen	Little interest or pleasure in doing things:		Not at All	Several Days	Nearly Every Day
	Feeling down, depressed, or hopeless:		Not at All	Several Days	Nearly Every Day