



Baylor Scott & White

HEALTH TEXAS PROVIDER NETWORK

Name: _____

DOB: _____

Date: _____

Thank you for choosing Baylor Scott & White Family Medical Center. 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 for visit:

Allergies:

List any significant reactions to food/meds

No allergies

	Allergy	Reaction
1.		
2.		

Medications

List any medications you take, prescription and nonprescription and their dosage:

No medications

	Medication	Dose	Refill needed (Y/N)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Local Pharmacy: _____ Phone Number: _____

Address: _____ City: _____

Mail order Pharmacy: _____

Past Medical History: Please 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
<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

Surgical History: Please Check all that apply:

No surgeries

<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 R/L
<input type="checkbox"/>	Breast Enhancement
<input type="checkbox"/>	Breast Surgery R/L
<input type="checkbox"/>	CABG-Heart bypass
<input type="checkbox"/>	Cardiac Catheterization
<input type="checkbox"/>	Carotid Endarterectomy
<input type="checkbox"/>	Carpal Tunnel surgery R/L
<input type="checkbox"/>	Cataract Surgery R/L

<input type="checkbox"/>	Cerebral Aneurysm
<input type="checkbox"/>	Gall Bladder removal
<input type="checkbox"/>	Colon Surgery
<input type="checkbox"/>	Heart Transplant
<input type="checkbox"/>	Hip Surgery R/L
<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Hysterectomy with ovaries removed
<input type="checkbox"/>	Kidney removal R/L
<input type="checkbox"/>	Kidney Transplant
<input type="checkbox"/>	Knee arthroscopy
<input type="checkbox"/>	Knee Surgery R/L

<input type="checkbox"/>	Liver Transplant
<input type="checkbox"/>	Lung Transplant
<input type="checkbox"/>	Masectomy (breast removal) R/L
<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: Please 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 cigarettes Snuff Chew

Year Started _____ Packs/day _____ Quit Date _____

Occupation: _____

Marital status: Single Married Divorced Widowed

Number of children: _____

Years of education: _____

Who do you live with? _____

OB/Gyn History:

Last Menstrual period:

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

of pregnancies: _____ # of miscarriages: _____ # of abortions: _____

Immunizations:

 Please enter the dates of your most recent vaccinations

Tetanus/Tdap/Td: _____ Human Papilloma Vaccination (HPV)/Gardasil: _____

Pevnar: _____ Pneumovax: _____

Zostavax /Shingles Vaccination: _____ Influenza Vaccination _____

Preventative care:

 Please enter the dates of your most recent tests

	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
Osteoporosis Test/DEXA		
<i>For Women Only</i>		
Pap Smear		
Mammogram		
Breast Exam		
<i>For Men Only</i>		
Last Prostate exam		

PSA		
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Have you had any of these symptoms in the last 2 weeks

<u>Constitution</u>			<u>Eyes</u>			<u>Endocrine</u>			<u>Allergy/Immunology</u>		
yes	Activity Change	no	yes	Eye Discharge	no	yes	Cold Intolerance	no	yes	Environmental Allergies	no
yes	Appetite Change	no	yes	Eye Itching	no	yes	Heat Intolerance	no	yes	Food Allergies	no
yes	Chills	no	yes	Eye Pain	no	yes	Polydipsia	no	yes	Immunocompromised	no
yes	Diaphoresis	no	yes	Eye Redness	no	yes	Polyphagia	no	<u>Neurological</u>		
yes	Fatigue	no	yes	Photophobia	no	yes	Polyuria	no			
yes	Fever	no	yes	Visual Disturbance	no	<u>GU</u>			yes	Dizziness	no
yes	Unexpected Weight Change	no	<u>Respiratory</u>						yes	Difficulty Urinating	no
<u>HENT</u>						yes	Apnea	no	yes	Dyspareunia	no
			yes	Congestion	no	yes	Chest Tightness	no	yes	Dysuria	no
yes	Dental Problem	no	yes	Choking	no	yes	Enuresis	no	yes	Numbness	no
yes	Drooling	no	yes	Cough	no	yes	Flank Pain	no	yes	Seizures	no
yes	Ear Discharge	no	yes	Shortness of Breath	no	yes	Frequency	no	yes	Speech Difficulty	no
yes	Ear Pain	no	yes	Stridor	no	yes	Genital Sore	no	yes	Syncope	no
yes	Facial Swelling	no	yes	Wheezing	no	yes	Hematuria	no	yes	Tremors	no
yes	Hearing Loss	no	<u>Cardiovascular</u>			yes	Menstrual Problem	no	<u>Hematologic</u>		
yes	Mouth Sores	no				yes	Chest Pain	no			
yes	Nosebleeds	no	yes	Leg Swelling	no	yes	Urgency	no	yes	Adenopathy	no
yes	Postnasal Drip	no	yes	Palitations	no	yes	Urine Decreased	no	yes	Bruises easily	no
yes	Rhinorrhea	no	<u>GI</u>			yes	Vaginal Bleeding	no	<u>Psychiatric</u>		
yes	Sinus Pressure	no				yes	Abdominal Distention	no			
yes	Sneezing	no	yes	Abdominal Pain	no	yes	Vaginal Pain	no	yes	Agitation	no
yes	Sore Throat	no	<u>Muscular</u>						yes	Behavior Problem	no
yes	Tinnitus	no							yes	Anal Bleeding	no
yes	Trouble Swallowing	no	yes	Blood in Stool	no	yes	Back Pain	no	yes	Decreased Concentration	no
yes	Voice Change	no	yes	Constipations	no	yes	Gait Problem	no	yes	Dysphoric Mood	no
			yes	Diarrhea	no	yes	Joint Swelling	no	yes	Hallucinations	no
			yes	Nausea	no	yes	Myalgias	no	yes	Hyperactive	no
			yes	Rectal Pain	no	yes	Neck Pain	no	yes	Nervous/anxious	no
			yes	Vomiting	no	yes	Neck Stiffness	no	yes	Self-injury	no
						<u>SKIN</u>			yes	Sleep Disturbance	no
									yes	Suicidal Ideas	no
						yes	Color change	no			
						yes	Pallor	no			
						yes	Rash	no			
						yes	Wound	no			