BAYLOR FAMILY MEDICINE AT FLOWER MOUND

HEALTH HISTORY

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential. Thank you.

Occupation: _____

Drug Allergies & Reaction: _____

_____

Medications (include vitamins, over-the-counter meds, birth control): _____

_____

_____

Health Habits: Check & describe all that apply.

_____ Caffeine _____ _____ Tobacco _____

_____ Alcohol _____ _____ Drugs _____

_____ Exercise _____ _____ Diet _____

Women: Date of last period _____ Mentrual History _____

Contraceptive Method _____ Any problems? _____

_____

Medical Illnesses (e.g. diabetes, cancer, lung/heart/stomach/kidney/liver disease, nervous or psychiatric disorders):

_____

_____

_____

Surgeries / Hospitalizations (e.g. appendix, tonsils, hysterectomy, vasectomy, etc.):

_____

_____

_____

Family History:

	Living?	Age/age at death	Describe any health problem/cause of death
Father			
Mother			
Brothers / Sisters			

Please list any "family" illnesses: _____

Health Maintenance: Please indicate the year you last had any of the following:

TB Skin Test _____ Pap Smear _____ **Immunizations:** Hepatitis A / B _____

Eye Exam _____ Mammogram _____ Tetanus _____ Pneumovax _____

Proctoscopy _____ Cholesterol _____ Influenza _____ Other _____

Please check symptoms you currently have or suffer from on a chronic basis.

NAME

DATE

X	GENERAL	X	GASTROINTESTINAL	X	MEN only
	Chills / Sweats		Poor Appetite		Breast lump
	Depression		Bloating		Erection difficulties
	Dizziness		Bowel changes		Problems with sex life
	Fainting		Constipation		Lump in testicles
	Fever		Diarrhea		Penis discharge
	Forgetfulness / Poor memory		Excessive gas		Sore on penis
	Headache		Excessive thirst		Urinary dribbling
	Difficulty sleeping		Hemorrhoids		Weak urinary flow
	Loss / Gain of weight		Indigestion		
	Nervousness / Anxiety		Nausea / vomiting		**WOMEN only**
	Fatigue		Black / Bloody Stools		Abnormal pap smear
	Poor Concentration		Stomach pain		Bleeding between periods
	Temperature Intolerance				Breast lump
			CARDIOVASCULAR		Breast pain
	MUSCLE / JOINT / BONE		Chest pain		Menstrual pain
	Pain, weakness, numbness in:		High Blood Pressure		Hot flashes
	Arms / Hands		Irregular Heart Beat		Nipple discharge
	Legs / Feet		Palpitations		Painful intercourse
	Back / Hips		Poor Circulations		Problems with sex life
	Neck / Shoulders		Swelling of ankles		Vaginal discharge
			Varicose veins		Vaginal itching
	SKIN		Exercise intolerance		Premenstrual symptoms
	Bruise easily				
	Hives		**PULMONARY**		**OTHER**
	Itching / dryness		Persistent cough		
	Changes in moles		Cough up blood		
	Rash		Shortness of breath		
	Sores that won't heal		Wheezing		
	Nail changes		Night sweats		
	EYE, EAR, NOSE, THROAT		**GENITO-URINARY**		
	Vision disturbances		Blood in urine		
	Difficulty swallowing		Frequent urination		
	Earache		Lack of bladder control		
	Ear drainage		Painful urination		
	Hay fever / allergies		Frequent infection		
	Hoarseness		Kidney Stone		
	Loss of hearing				
	Nosebleeds				
	Sinus problems				
	Dental problems				
	Bleeding gums				