Colleyville Family Medicine

A Baylor Scott & White Health - HealthTexas Affiliate

5232 Colleyville Blvd, Suite 100
Colleyville, Texas 76034
Phone: (817) 912-9920 Fax: (817) 498-0635

Date:_____/_____/_____

Dear:_____,

Your Physical Exam is scheduled on:

_____, _____/_____/_____ at _____ a.m. / p.m.

- **Please complete the enclosed forms and bring them with you at the time of your appointment.**

- Wellness exams frequently require laboratory evaluation and testing with a thorough physical exam. Please wear appropriate clothing to allow easy changing.

- If your scheduled appointment is in the morning, laboratory work may be needed, so please do **not** eat or drink anything 12 hours prior to your appointment time. **You may have water, all the water you want during your fast, and one cup of black coffee, or one cup of black non-herbal tea.**

- If your wellness exam is scheduled in the afternoon, it will require a long period of fasting and your options are as follows:

    1. You may elect not to eat or drink for 12 hours prior to your appointment time **(you may have all the water that you want during your fast, and one cup of black coffee, or one cup of black non-herbal tea).** Labs can then be drawn at the time of your afternoon appointment.
    2. We will perform your exam and order the laboratory tests to be drawn at a later date.

- If you are unable to keep this appointment please notify us as soon as possible so we can fill your appointment slot with another patient. If you fail to cancel the appointment within **24 hour notice**, you will be billed $100.00 cancellation fee.

If you have any questions or concerns, please call our office at (817) 912-9920.

Sincerely,

Physicians & Staff at Colleyville Family Medicine

Colleyville Family Medicine
Medical History for the Initial Exam

Note to the patient: This is a very detailed and thorough medical history form. The more knowledge about your medical history is gained, the better I will be able to assist in helping you manage all your health care needs. Some of the questions are very personal in nature and may be difficult or embarrassing for you to answer. I can assure you that they are very important or they would not be asked. Your medical record is being kept in complete confidence. We only release your medical information upon your signed consent. *Therefore, please take your time and complete this form as accurately as possible.*

Name: _____ **Age:**_____ **Date Completed:** _____/_____/_____
Last Name First Name MI

Race: O Caucasian O Black O Hispanic O Asian O American Indian O Other _____

Date of Birth: _____/_____/_____ **Place of Birth:** _____

Please rate what you consider to be your overall general health: (Poor) O 1 O 2 O 3 O 4 O 5 (Good)

Allergies: (Please list any allergies you have to medications, foods or environmental substances)

Allergy	**What happens when you are exposed to this?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications: (include those prescribed and those purchased over the counter. Include vitamins, herbs, laxatives and cold medicines)

Name of Medication	**Strength**	**How often Taken?**	**How long have you been on this medication (years)?**	**Prescribed by (Dr's Name)**

Travel History: (Indicate if you have traveled out of the country in the last 24 months)

Place of visit outside of the Unites States	**Visited**	**Lived**	**How Long in months / years**
_____	O	O	_____
_____	O	O	_____
_____	O	O	_____
_____	O	O	_____

Past Medical History: (Place a check if you have ever had any of the following diseases, and the age if remembered)

_____ Measles	**_____ Mumps**	**_____ Chicken Pox**	**_____ Pertussis**	**_____ Strep Throat**
_____ Rheumatic Fever	**_____ Meningitis**	**_____ Influenza**	**_____ Pneumonia**	**_____ Pleurisy**
_____ Tuberculosis	**_____ Small Pox**	**_____ Polio**	**_____ Prostatits**	**_____ Bronchitis**
_____ Hepatitis	**_____ Venereal Disease**	**_____ UTI**	**_____ Mononucleosis**	**_____ Shingles**

_____ Cancer (type) _____	**_____ Diabetes**	**_____ Thyroid Disease**	**_____ Glaucoma**
_____ Anemia (low red blood count)	**_____ Cataracts**	**_____ Endometriosis**	**_____ Migraine Headache**
_____ Phlebitis (vein inflammation)	**_____ Endometriosis**	**_____ Protein in Urine**	**_____ Stroke**
_____ Hay Fever or Sinus Problems	**_____ High Blood Pressure**	**_____ Heart Murmur**	**_____ Emphysema**
_____ Heart Disease or Attack	**_____ High Cholesterol**	**_____ Blood Clot**	**_____ Stomach Ulcer**
_____ Pulmonary Embolism	**_____ Cirrhosis**		

_____ Gallstones	**_____ Gallbladder Infection**	**_____ Kidney Stones**	**_____ Pancreatitis**	**_____ Hernia**
_____ Infertility	**_____ Arthritis**	**_____ Gout**	**_____ Seizures**	**_____ Birth Defect**
_____ Bleeding Problems	**_____ Major Trauma**	**_____ Physical Disability**	**_____ Learning Disability**	
_____ Depression or Mental Illness		**_____ Radiation Exposure (other than X-Rays)**		

Surgical History:

Surgical Procedure	Year	Hospital	Doctor

Injuries:

Age and/or year	Description	Treatment	Doctor

Hospitalizations:

Age and or/year	Description	Treatment	Doctor

Social History:

Status: O Married (number of times _____) O Single O Widowed O Divorced O Separated

What level of education did you achieve? O Didn't finish school O High School O College O Graduate

How many people, other than yourself, are living in your home? _____

Please list the names and ages of your children: (If *your* children, indicate if vaginal (SVD) or cesarean section (C/S))

Name	Delivery Type	Age	Type
	O SVD O C/S		O Biological O Step
	O SVD O C/S		O Biological O Step
	O SVD O C/S		O Biological O Step
	O SVD O C/S		O Biological O Step
	O SVD O C/S		O Biological O Step

Occupation:

Title/Position Company How long have you worked there?

_____

Have you been exposed to hazardous materials at this job or any previous jobs? O Yes O No **If yes, complete the following:**

Hazardous Material Company Illnesses & treatment (as a result of exposure)

_____

Family History:

	Age if living	Note any medical problems from list below	Age deceased	Cause of death
Mother				
Father				
Brothers: Number alive:				
Number dead:				
Sisters: Number alive:				
Number dead:				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				

Family Medical Problems:

_____ Obesity _____ High Blood Pressure _____ Heart Murmur _____ Diabetes _____ High Cholesterol or Triglycerides

_____ Colon Polyps _____ Tuberculosis _____ Lung Disease _____ Seizures _____ Physical Disability _____ Allergies

_____ Anemia _____ Heart Disease _____ Liver Disease _____ Stroke _____ Kidney Disease _____ Glaucoma

_____ Arthritis _____ Thyroid Disease _____ Bleeding Problems _____ Asthma _____ Birth Defects _____ Alcoholism

_____ Cancer (type) _____ _____ Psychiatric (mental illness)

Nutrition:

How many meals do you eat per day? _____ Are you happy with your current weight? O Yes O No

Do you ever binge? O Yes O No Do you ever vomit or use laxatives for weight control? O Yes O No

Do you take vitamins or eat "health foods" for weight management? O Yes O No

*** If yes, to any of the above questions, please list more detail: _____

Prevention:

Do you exercise on a regular basis? O Yes O No How many days per week? _____ How long do you exercise? _____

***If yes, what type of exercise? O Weights O Running O Aerobics O Other: _____

How often do you see a doctor? O Regular visits/prevention O Only when ill

When was the last time you saw the eye doctor? _____ The dentist? _____

Have you ever had your hearing checked? O Yes O No If yes, when: _____/_____/_____

Immunizations: (Immunization history is important and if you have a record, please provide a copy to your provider)

Date of last: Flu Shot _____ Tetanus Shot _____ Pneumovax _____

TB Skin Test _____ Results: O Negative O Positive Ever been treated for TB? O Yes O No

Date of last: Complete history & Physical Exam _____ Blood Test: _____

EKG _____ Have you ever had an Abnormal EKG? O Yes O No

Chest X-Ray _____ Have you ever had an Abnormal Chest X-Ray? O Yes O No

Habits:

How often do you drink alcoholic beverages? O Daily O Weekly O Monthly O Less than once a month O Never

What do you drink? O Wine O Beer O Mixed Drinks How much do you consume at a sitting? _____

I stopped drinking alcohol since: _____

Do you smoke cigarettes or cigars? O Yes O No If yes, how many packs per day? _____ How long? _____ years

Do you or have you used any other tobacco products? O Yes O No Type: O Dip O Chew O Pipe O Other

Have you ever used street drugs (marijuana, cocaine, Quaalude, methamphetamine, ecstasy)? O Yes O No

If yes, what type(s): _____ Ever used needles? O Yes O No

Do you still use street drugs? O Yes O No If no, when did you stop? _____ If yes, when last used? _____

Sexual History:

Do you consider yourself: O heterosexual O homosexual O bisexual

Have you had more than one sexual partner in the past year? O Yes O No

Have you ever been a victim of sexual abuse? O Yes O No If yes, have you received counseling? O Yes O No

Do you ever feel like you may have been drugged before having sex? O Yes O No

Risk factors for HIV (Human Immune Deficiency Virus)

Do you have any tattoos? O Yes O No Have you had any homosexual or bisexual relations? O Yes O No

Have you had sex with a known IV drug user? O Yes O No Prostitute? O Yes O No

Promiscuous partner O Yes O No

Have you ever had a blood transfusion? O Yes O No If yes, when? _____

Women Only: Gynecologic History **(Men Continue with System Review on Next Page)**

Age at first period? _____ Age at first intercourse? _____ Age you stopped having periods? _____ O Not stopped

Do you use birth control? O Yes O No **If yes, what type:** O Pill O Patch O Condom O Depo Provera Injection O IUD O Other

Menstrual cycle: occurs every _____ days Duration (time of period) _____ days The flow is: O Heavy O Moderate O Light

Do you have cramps requiring medication during period? O Yes O No List any premenstrual symptoms you have: _____

Date of last mammogram? _____ Have you ever had an abnormal mammogram? O Yes O No

If yes, when? _____ What was the treatment? _____

Date of last pap smear? _____ Have you ever had an abnormal pap smear? O Yes O No

If yes, when? _____ What was the treatment? _____

Do you do self breast exams? O Yes O No If no, has anyone ever taught you how? O Yes O No

Women Only: Obstetrics History

Age at first pregnancy: _____ How many total times have you been pregnant? _____ How many deliveries? _____

Number of full term infants (38-42 weeks): _____ Number of premature infants (37 weeks): _____ Number of elective abortions: _____

Number of miscarriages: _____ Number of vaginal deliveries: _____ Number of cesarean sections: _____ Number of living children: _____

Did you have any complications before, during or after any of your deliveries, involving you or the infant? O Yes O No

If yes, please explain: _____

Will you describe the cause of death for any of your children? _____

System Review: (place a check by any of the following that you are currently experiencing and not previously evaluated by a doctor)

General:

_____ **Fatigue**
_____ **Swollen lymph glands**
_____ **Difficulty sleeping**
_____ **Poor sexual drive (desire)**
_____ **Mouth ulcers**
_____ **Sore throat**
_____ **Dental problems**
_____ **Bleeding gums**
_____ **Hoarseness**
_____ **Teeth grinding**
_____ **Dentures**
_____ ***None of the above***

Skin:

_____ **Sores**
_____ **Bruises**
_____ **Rash**
_____ **Dryness**
_____ **Hair loss**
_____ **Nail changes**
_____ **Change in wart or moles**
_____ ***None of the above***

Neck:

_____ **Pain in motion**
_____ **Masses**
_____ **Stiffness**
_____ **Swelling**
_____ ***None of the above***

Head and Eyes:

_____ **Headaches**
_____ **Dry eyes**
_____ **Eye infection**
_____ **Watery eyes**
_____ **Eye pain**
_____ **Blurred vision**
_____ **Double vision**
_____ **Sensitivity to light**
_____ **Seeing "spots"**
_____ **Farsightedness**
_____ **Nearsightedness**
_____ **Wear glasses**
_____ **Wear contacts**
_____ ***None of the above***

Ear/Nose/Throat:

_____ **Difficulty hearing**
_____ **Ringing in the ears**
_____ **Ear infection**
_____ **Ruptured ear drum**
_____ **Dizziness**
_____ **Ear pain**
_____ **Hearing aid**
_____ **Nose bleeds**
_____ **Nasal polyps**
_____ **Nasal stuffiness**
_____ **Sinusitis**
_____ **Decrease in smell**
_____ **Runny nose**
_____ **Dry mouth**
_____ **Cold sores or Fever blisters**
_____ ***None of the above***

Cardiopulmonary:

_____ **Snoring**
_____ **Cough**
_____ **Sputum production**
_____ **Coughing up blood**
_____ **Shortness of breath (at rest)**
_____ **Shortness of breath (with activity)**
_____ **Wheezing**
_____ **Pain with breathing**
_____ **Fever**
_____ **Shaking chills**
_____ **Night sweats**
_____ **Requiring more than one pillow to aid breathing**
_____ **Rapid heartbeat**
_____ **Heart skips a beat**
_____ **Palpitations**
_____ **Chest pain**
_____ **varicose veins**
_____ **Pain in arm, neck or jaw**
_____ **Poor circulation**
_____ **Swelling of ankles or feet**
_____ **Leg cramps**
_____ **Fainting spells**
_____ ***None of the above***

Gastrointestinal:

_____ **Difficulty swallowing**
_____ **Pain with swallowing**
_____ **Frequent belching (burping)**
_____ **Heart burn**
_____ **Frequent us of antacids**
_____ **Nausea**
_____ **Vomiting**
_____ **Vomiting blood**
_____ **Diarrhea**
_____ **Constipation**
_____ **Black stools**
_____ **Mucous in stools**
_____ **Blood in stools or on toilet paper**
_____ **Loss of control of bowel movement**
_____ **Hemorrhoids**
_____ **Jaundice (yellow skin)**
_____ **Change in weight**
_____ **Change in appetite**
_____ **Food tolerance (upset stomach)**
_____ **Excessive gas**
_____ **Hiccups (recurrent)**
_____ **Feeling of fullness after small food intake**
_____ **Pain with passage of bowel movement**
_____ **Change in color or appearance of bowel movement**
_____ **Abdominal pain or cramping**
_____ ***None of the above***

Genitourinary:

_____ **Need to urinate more frequently than normal**
_____ **Burning with urination**
_____ **Urgent need to urinate**
_____ **Blood in urine**
_____ **Leakage of urine (unable to hold it)**
_____ **Get up at night to urinate**
_____ **Difficulty starting/stopping urinary stream**
_____ ***None of the above***

Men Only:

_____ **Ulcers or lesions**
_____ **Discharge from penis**
_____ **Inability to gain or maintain erection**
_____ **Masses or swelling of testicles**
_____ **Pain in testicles**
_____ **Pain in groin with lifting or straining**
_____ **Dribbling after urination**
_____ ***None of the above***

Women Only:

_____ **Vaginal discharge**
_____ **Vaginal dryness**
_____ **Vaginal itching**
_____ **Pain with sex**
_____ **Ulcers or lesions on genital area**
_____ **Pelvic pain**
_____ **Menstrual problems**
_____ **Breast lump**
_____ **Breast discharge**
_____ ***None of the above***

Neuromuscular & Musculoskeletal:

_____ **Right handed**
_____ **Left handed**
_____ **Involuntary tremor (hands shake)**
_____ **Loss of sensation in hands or feet**
_____ **Tingling in hands or feet**
_____ **Inability to move arms or legs**
_____ **Convulsions**
_____ **Swelling of joints**
_____ **Pain in joints**
_____ **Deformed joints**
_____ **Stiff joints**
_____ **Pain in muscles**
_____ **Low back pain**
_____ **Difficulty walking**
_____ **Difficulty balancing**
_____ **Difficulty standing**
_____ **Difficulty lifting**
_____ **Difficulty stooping, bending, or squatting**
_____ **Frequent falls**
_____ **Heel pain**
_____ **Weakness**
_____ **Increased sensation**
_____ **Poor condition**
_____ ***None of the above***

Neuropsychological:

_____ **Personality change**
_____ **Difficulty speaking**
_____ **Confusion**
_____ **Memory loss**
_____ **Change in speech**
_____ **Change in behavior**
_____ **Suicidal thoughts**
_____ **Feelings of sadness/depression**
_____ **Anxiety (nervousness)**
_____ ***None of the above***

Hematological:

_____ **Easy bleeding**
_____ **Easy bruising**
_____ **Paleness**
_____ ***None of the above***

Endocrine:

_____ **Always thirsty**
_____ **Always hungry**
_____ **Intolerant to cold or heat**
_____ **Change in hair texture**
_____ **Increased body hair (Women)**
_____ **Inability to gain or lose weight**
_____ ***None of the above***

Anything else you wish the doctor to know or have concerns about?

_____

_____

_____

_____

_____
Signature of person completing this form

(For Physicians Only)

O I have read and reviewed this completed Medical History and ROS Form

Date: _____/_____/_____ _____
Initials or Signature of Physician