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 Subsequent Exam

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

Please note: *Please take your time and answer each question carefully and as complete as possible.*

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)

Have you had any surgeries or hospitalizations since last visit? O Yes O No
If yes, please list:

Type of Care/Surgery	**Date of Care**	**Place of Care**
_____	_____	_____
_____	_____	_____

Has your occupation changed since your last physical? O Yes O No
If yes, list new occupation:
_____

Has your marital status changed since the last physical? O Yes O No
If yes, please indicate: O Divorce O Marriage O Widow O Separated

Have any new diseases been diagnosed in your family since the last physical? O Yes O No
(parents, siblings, grandparents) If yes, please list:

Family Member	**Disease**
_____	_____
_____	_____

Are you exercising regularly? O Yes O No
If yes, list activity: _____

Have you quit smoking since your last physical? O Yes O No
Have you started smoking since your last physical? O Yes O No If yes, how many packs per day? _____
How many ounces of alcohol do you drink per week? _____ **O I don't drink at all**
Do you use any street drugs? O Yes O No

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	_____

Sexual History:

Do you consider yourself: O Heterosexual O Homosexual O Bisexual

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

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: _____

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 know IV drug user? O Yes O No **Prostitute?** O Yes O No

Promiscuous partner O Yes O No

Last exam by eye doctor? _____/_____ (month/year)

Last exam by dentist? _____/_____ (month/year) **Do you maintain regular visits?** O Yes O No

For Women: If Gynecology care received outside this office, please give date of:

Last PAP: _____/_____ (month/year) **Last Mammogram:** _____/_____ (month/year)

Performed by doctor: _____

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***

Cardiopulmonary:

_____ **Snoring**
_____ **Cough**
_____ **Sputum production**
_____ **Coughing up blood**
_____ **Shortness of breath (at rest)**
_____ **Shortness of breath (with activity)**
_____ **Wheezing**

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***

Gastrointestinal:

_____ **Difficulty swallowing**
_____ **Pain with swallowing**
_____ **Frequent belching (burping)**
_____ **Heart burn**
_____ **Frequent us of antacids**
_____ **Nausea**
_____ **Vomiting**

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***

Hematological:

_____ **Easy bleeding**
_____ **Easy bruising**
_____ **Paleness**
_____ ***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**

_____ **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***

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***

_____ **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***

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***

_____ **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***

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: _____/_____/_____ _____