Family Medical Center at Baylor
3600 Gaston Avenue Barnett Tower #1109 Dallas, Texas 75246
Phone 972-817-6930 Fax 972-817-6940

Dana A. Bleakney, MD / Rachael C. Evans, DO / Laura T. Nguyen, MD / Melanie L. Reed, MD / Matthew P. Sokol, MD
Cayla Schaner, PA-C / Shannon Smothers, PA-C

PAST MEDICAL HISTORY: Please check any of the following medical conditions you have had in the past.
Please note date of onset/diagnosis: (Ex. ☒ Diabetes – 1979)

- ☐ Abnormal Heart Rhythm
- ☐ Allergic Rhinitis
- ☐ Anemia/Blood Disorder
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer, Type_____
- ☐ Chest Pain
- ☐ Colon Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gastro-Esophageal Reflux Disease
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Problems
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Migraine Headaches
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke/TIA
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Tuberculosis

OTHER MEDICAL HISTORY List any other medical conditions you have been diagnosed with and the date of onset:

_____
_____

SURGICAL HISTORY List all surgeries with dates they occurred:

_____
_____
_____
_____

FAMILY HISTORY

RELATIONSHIP	LIVING?	PRESENT MEDICAL PROBLEMS / CAUSE OF DEATH
MOTHER/MATERNAL	☐ Yes ☐ No	_____
FATHER/PATERNAL	☐ Yes ☐ No	_____
SIBLINGS		
_____		_____
_____		_____
_____		_____
_____		_____

Please check box for any of the following medical conditions in your extended family members and indicated relation in brackets ( ) Ex. ☒ Asthma (MATERNAL Aunt)

- ☐ Allergic Rhinitis
- ☐ Anemia/Blood Disorder
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer, Type _____
- ☐ Colon Problems
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Glaucoma
- ☐ Heart Attack/Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Migraine
- ☐ Osteoporosis
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PATIENT NAME: _____ DOB: _____

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SOCIAL HISTORY

OCCUPATION: _____

RELATIONSHIP STATUS: ☐Single ☐Married ☐Widowed ☐Divorced ☐Common-Law Married ☐Other

Do you think of yourself as;
☐gay, ☐lesbian, or ☐homosexual
☐straight, or ☐heterosexual
☐Bisexual
Do you identify yourself as a transsexual or transgendered?
☐yes ☐no

TOBACCO USE: ☐ Never ☐ Currently ☐ In the past (amount/day _____ # years used_____)

MEDICATIONS: (List ALL medications, prescribed and over the counter, herbs and supplements):

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS: (List allergies to medications ONLY and the type of reaction to each):

_____
_____
_____
_____
_____
_____

Pharmacy: Phone number and cross street of pharmacy where we will send your medications now or in the Future. Otherwise, you may have to return to pick up handwritten prescriptions if needed.

Pharmacy: _____ Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

PATIENT NAME: _____ DOB: _____

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HEALTH MAINTENANCE / SCREENING:

Please list the most approximate date for the following preventative services. Depending on your age/sex all categories may not be applicable for you. On the services that list Normal/Abnormal or Not sure, please circle one.

	Date of last:		Date of last:		Date of last:
Tdap: (tetanus/whooping cough)		**Mammogram:** Normal / Abnormal / Not Sure		**Colon Cancer Screening:** (Fit test, Cologuard, Colonoscopy)	
Pneumonia Vaccine(s): Prevnar / Pneumovax / Not sure		**Pap Smear:** Normal / Abnormal / Not Sure		**Hepatitis C Blood test:**	
Shingles Vaccine(s): Zostavax/Shingrix Not sure		**Bone Density test:** Normal / Abnormal / Not sure		**Flu Vaccine:**	

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