Baylor Family Medicine at Cedar Hill

Health History Form

Name:_____ **Today's Date:**_____

Date of Birth: _____/_____/_____ **Who Referred You?** _____

Main Complaint (what you'd like addressed today?)_____

Medical Problems? (*Diabetes, High Blood Pressure, etc.)* **No** ◯ **Yes** ◯ *If Yes, please list them:*

_____

_____

Surgeries or Hospitalizations? No ◯ **Yes** ◯ *If Yes, please list them with approximate dates:*

_____

_____

Allergies? (*Food, Drugs, etc.)* **No** ◯ **Yes** ◯ *If Yes, please list them:*

_____

_____

Family History

Family Members	***Alive***	***Deceased***	***Age of Death***	***Any Medical Problems?***
Father	◯	◯		
Mother	◯	◯		
Brother	◯	◯		
Sister	◯	◯		
Son	◯	◯		
Daughter	◯	◯		
Paternal Grandmother	◯	◯		
Paternal Grandfather	◯	◯		
Maternal Grandmother	◯	◯		
Maternal Grandfather	◯	◯		
Other Important Family History:				

Social History

Marital Status:	# of Children:	Occupation:
Frequency & Amount of Exercise:		Frequency & Amount of Alcohol:
Frequency & Amount of Tobacco:		Frequency & Amount of Drugs:

List any other physician you are seeing & reason why:

Physician:_____ Reason?_____

Physician:_____ Reason?_____

Physician:_____ Reason?_____

Medications (list all medications (prescription & over the counter) and all supplement that you take regularly)

Medication/Supplement	*Doses*	*Frequency*	*Reason*

Preventive Care History

Test or Vaccine	*Yes*	*No*	*Date of Test*	*Results*
PAP	◯	◯		
Mammogram	◯	◯		
Bone Density	◯	◯		
Prostate Check	◯	◯		
Colonoscopy Test	◯	◯		
Stool Test for Blood	◯	◯		
EKG or Stress Test	◯	◯		
Tuberculosis Skin Test	◯	◯		
Pneumonia Vaccine	◯	◯		
Flu Vaccine	◯	◯		
Tetanus Vaccine	◯	◯		
Shingles Vaccine	◯	◯		