Baylor Scott and White Family Medicine Keller

New Patient Health History

Name: ______________________________ Birth Date: ____/____/____ Today's date: ____/____/____

Caretaker/guardian's name (if applicable): ____

Current Medications (please list all medications and supplements)

Medication Name	*Dosage*	*Frequency*

Drug Allergies

Medication Name	*Reaction*

Preferred Pharmacy

Pharmacy Name	*Address*	*Telephone Number*

Past and Current Medical History

Medical Problem	*Year*	*Medical Problem*	*Year*

Surgical History

Surgery	*Year*	*Surgery*	*Year*

Diabetic Exams (only if you have diabetes)

	Month / Year	*Results*
Dilated eye exam		
Hemoglobin A1C		
Urine test for protein		

Specialists (cardiologist, eye doctor, gynecologist, gastroenterologist, etc.)

Name	*Specialty*

Obstetrics History (females only)

Number of times you have been pregnant: ____

Number of deliveries (term vs pre-term):____

Family History

	Living or Deceased?	*Age/age at death*	*Health problems*
Mother			
Father			
Brother			
Sister			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Social History

Marital Status (circle one): Single / Married / Partnered / Divorced / Separated / Widowed

Occupation: ____________________________________ *Employer*: ______________________

Number and Ages of Children: ____

Tobacco Use (circle one): Current / Quit / Never

If Current: Year started ____________________

Cigarettes: _____ packs/day

Cigars: ________cigars/day

Smokeless: ________cans/day

Electronic cigarettes

If Quit: Year started _______ / Year Quit ______ / # packs per day you smoked _________

Recreational Drugs (circle one): Current / Quit / Never

If current: Type of substance ______________

Alcohol Use (circle one): Current / Socially / Quit / Never

If current: Type of alcohol ______________ Average # drinks per week __________

Sexual Activity (circle one): Yes / Not Currently / Never

Sexual Partner (circle): Female / Male / Both

Contraception method: ____

Health Maintenance

Preventive exams	*Date (most recent)*	*Results*
Mammogram		
Pap smear		
Bone density scan		
Colonoscopy		
Cologuard DNA stool test		
Fecal occult blood test		

Immunizations	*Month / Year*
Tetanus booster (circle one): Td / Tdap	
Flu	
Prevnar 13 (pneumonia)	
Pneumovax 23 (pneumonia)	
Zostavax (old shingles)	
Shingrix (new shingles)	
Hepatitis B	
Gardasil (HPV)	