Baylor Scott & White HEALTHTEXAS PROVIDER NETWORK

Patient Name: _____ DOB: _____ Date: _____

In your words, why have you been referred to our office: _____

_____

Medication Allergies and Reactions:

_____

_____

_____

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

Current Medications:

Medication	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History/Review of Systems: Circle below all that apply to you.

General
Anxiety
Change in Appetite (recent)
Change in Weight (recent)
Depression
Poor Memory
Suicidal thoughts
Weakness

Skin
Change in mole size
Eczema
Hives/Rashes
Skin Cancer

Head & Nervous System
Concussion
Confusion
Dizziness
Fainting or blackouts
Migraine or severe headache

Muscle weakness/problems speaking
Nervous or emotional problems
Numbness, tingling, or burning in hands or feet
Polio
Seizures/Epilepsy

Ears
Chronic ear infections
Deafness or trouble hearing
Ringing in ears

Eyes
Blindness
Cataracts
Change in eyesight
Glaucoma

Glands
Diabetes
Goiter
Hypothyroidism
Obesity
Overactive Thyroid
Thyroid disease

Lungs
Asthma
Bronchitis
Coughing up blood
Emphysema
Hay Fever
Nagging Cough
Pleurisy
Pneumonia
Shortness of breath
Tuberculosis

Heart
Atrial Fibrillation
Chest/Heart pain (angina)
Hear Attack
Heart failure
High Blood Pressure
High Cholesterol
Racing heart or palpitations
Rheumatic fever
Shortness of breath with work or exertion

Blood Vessels
Blood Clot
Stroke
Swelling in feet or ankles
Varicose veins

Bones and Joints
Arthritis
Broken bones
Chronic Back Pain
Gout

Blood
Anemia
Bleeding problems
Blood transfusion
Sickle cell disease or trait

Infections
Chicken Pox
Hepatitis A
Hepatitis B
Hepatitis C
HIV
Meningitis
Tuberculosis

Abdomen
Ascites
Black, tarry, or bloody stools
Bleeding varices
Cirrhosis
Colon Cancer
Constipation
Diverticulitis
Encephalopathy
Gallbladder infection
Gallstones
GERD
GI Bleed
Hemorrhoids
Hernias
Jaundice (yellowing of skin)
Pancreatitis
Polyps in colon
Trouble swallowing
Ulcer or stomach bleeding
Ulcers

Kidney/Urinary System
Frequent Urination
Kidney Failure
Kidney or bladder infection
Kidney Stones
Other kidney disease
Prostate Cancer
Renal Insufficiency
Unable to control urination

Other
Cancer
Hoarseness

Immunizations
Hepatitis A: Year: _____
Hepatitis B: Year: _____
Tetanus: Year: _____
Pneumonia: Year: _____
Flu: Year: _____

Prior Testing
EKG: Year: _____
Endoscopy (EGD): Year: _____
Colonoscopy: Year: _____

Any additional medical history:

_____

_____

_____

_____

_____

_____

_____

Surgical History:

	Y / N		Y / N
Abdominal Aneurysm	_____	Kidney Removal	_____
Appendectomy	_____	Kidney Transplant	_____
Back Surgery	_____	Knee Arthroscopy	_____
Bariatric Surgery	_____	Knee Surgery	_____
Brain Surgery	_____	Liver Transplant	_____
CABG	_____	Lung Transplant	_____
Cardiac Catheterization	_____	Neck Surgery	_____
Carotid endarterectomy	_____	Percutaneous Trans. Coronary Angioplasty	_____
Carpal Tunnel Release	_____	Pneumonectomy	_____
Cataract Removal/IOL Implant	_____	Prostate Surgery	_____
Cerebral Aneurysms	_____	Shoulder Surgery	_____
Cholecystectomy	_____	Sinus Surgery	_____
Colon Surgery	_____	Tonsillectomy	_____
Femoral Popliteal Bypass	_____	Valve Replacement	_____
Heart Transplant	_____	Vasectomy	_____
Hip Surgery	_____	Other: _____	

Family History:

	Y/N	Family Member
Diabetes	_____	_____
High Blood Pressure	_____	_____
Kidney Disease	_____	_____
Heart Disease	_____	_____
Liver Disease	_____	_____
Stroke	_____	_____
Seizures/Epilepsy	_____	_____
Cancer	_____	_____
Other: _____	_____	_____

Social History:

Are you currently working? Yes ☐ No ☐

If yes, what is your occupation? _____

Tobacco Use: Yes ☐ No ☐

Current or Past: _____ Quit Date: _____

Type: ☐ cigarettes ☐ e-cigs ☐ Smokeless ☐Pipe ☐ Cigars

Packs per Day: _____ # of Years: _____

Alcohol Use: Yes ☐ No ☐

Drinks per week: _____ Glasses of wine: _____ Cans of Beer: _____
Shots of Liquor: _____ Standard drinks/equivalent: _____

Has anyone close to you every thought you drank too much? Yes ☐ No ☐

Have you ever participated in AA or other replapse prevention program? Yes ☐ No ☐

Have you ever used recreational/illegal drugs? Yes ☐ No ☐

Type: _____

Have you ever used IV drugs or cocaine? Yes ☐ No ☐ Which? _____

Have you ever had a tattoo? Yes ☐ No ☐

Marital Status:

Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

Sexually Active? Yes ☐ No ☐ Not Currently ☐ Partners: Male ☐ Female ☐

Birth Control/protection: Yes ☐ No ☐

If yes, type: _____