Baylor Scott & White
PRIMARY CARE
MCKINNEY
A member of HealthTexas Provider Network

Name: _____

DOB: _____

Date: _____

MRN#: _____

Thank you for choosing Baylor Scott & White Primary Care - McKinney. We appreciate your assistance by completing this form, as it will help us better care for you.

Were you referred by another physician? If so, who?

_____

Reason for visit:

_____

Allergies:

List any significant reactions to food/meds ☐ No known allergies

	Allergy	Reaction
1.		
2.		

Medications

List any medications you take, prescription and nonprescription and their dosage: ☐ No medications

	Medication	Dose	Refill needed (Y/N)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Local Pharmacy: _____ **Phone Number:** _____

Address: _____ **City:** _____

Mail order Pharmacy: _____

Your Care Team: Please provide the names of any other providers that you currently receive care from.

Past Medical History: Please check all that apply. ☐ No medical problems

	Abnormal pap smear
	Anemia
	Anxiety
	Asthma
	Atrial fibrillation
	Breast cancer
	Cervical cancer
	Chicken pox
	Chronic Back pain
	Colon cancer
	Deep Vein Thrombosis

	Depression
	GERD
	Gestational Diabetes
	GI bleed
	Gout
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Hypertension
	Hyperthyroidism

	Hypothyroidism
	Kidney Stone
	Heart attack
	Kidney Failure
	Kidney Disease
	Seizures
	Skin Cancer
	Stroke
	Substance Abuse
	Ulcers

Additional History: _____

_____

Surgical History: Please Check all that apply: ☐ No surgeries

	Abdominal aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Brain Surgery
	Breast Biopsy R/L
	Breast Enhancement
	Breast Surgery R/L
	CABG-Heart bypass
	Cardiac Catheterization

	Cerebral Aneurysm
	Gall Bladder removal
	Colon Surgery
	Heart Transplant
	Hip Surgery R/L
	Hysterectomy
	Hysterectomy with ovaries removed
	Kidney removal R/L
	Kidney Transplant
	Knee arthroscopy

	Liver Transplant
	Lung Transplant
	Mastectomy (breast removal) R/L
	Neck Surgery
	Previous C-section
	Shoulder Surgery R/L
	Sinus Surgery
	Tonsillectomy
	Tubal ligation (tubes tied)
	Valve replacement

	Carotid Endarterectomy		Knee Surgery R/L		Other:
	Carpal Tunnel surgery R/L				
	Cataract Surgery R/L				

Family History: Please check all that apply:

	None	Alcohol abuse	Alzheimer's	Asthma	Autoimmune	Breast cancer	Cancer	Colon Cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

Alcohol Use: ☐ Yes ☐ No

Number of drinks/week: _____ glasses of wine _____ cans of beer _____ shots of liquor _____

Sexually Active: ☐ Yes ☐ Not currently ☐Never

Type of birth control: _____ Partners**:** ☐ Female ☐ Male ☐ Both

Drug Use: ☐ Yes ☐ No ☐ Former Type of Drugs: _____

Tobacco Use: ☐ Yes ☐ No

If so what type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes ☐ Snuff ☐ Chew

Year Started: _____ Packs/day: _____ Quit Date: _____

Occupation: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children: _____

Years of education: _____

Who do you live with? _____

OB/Gyn History:

Last Menstrual period:

Duration of periods: _____ Interval between periods: _____ Heavy periods: ☐ Yes ☐ No

# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____

Immunizations: Please enter the dates of your most recent vaccinations

Tetanus/TdaP/Td: _____ **Human Papilloma Vaccination (HPV)/Gardasil:** _____

Prevnar: _____ **Pneumovax:** _____

Zostavax /Shingles Vaccination: _____ **Influenza Vaccination:** _____

Preventative Care: Please enter the dates of your most recent tests.

	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
Osteoporosis Test/DEXA		
For Women Only		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		
Last Prostate exam		
PSA		

Advanced Directives:

Do you have a living will**:** ☐ Yes ☐ No

Do you have a Medical Power of Attorney**:** ☐ Yes ☐ No

Do you have an out of hospital "Do Not Resuscitate" (DNR): ☐ Yes ☐ No

If you answered **YES** to any of these questions, please bring a copy of the legal document to your first visit.

If you answered **NO**, we have information that will be provided for you to discuss with your family so that Advanced Medical Directives can be incorporated into your medical chart.

REVIEW OF SYSTEMS QUESTIONNAIRE

In order to accurately assess your concerns, please CIRCLE any of the symptoms below that you have experienced in the past 2 weeks.

CONSTITUTIONAL	Activity Change	Appetite Change	Chills	Chronic Pain	Daytime Sleepiness
	Execessive Sweating	Fatigue	Fever	Unexpected Wt Change	
HENT	Congestion	Dental Problem	Drooling	Ear Pain	Facial Swelling
	Hearing Loss	Mouth Sores	Nosebleeds	Post Nasal Drip	Reflux
	Runny Nose	Sinus Pain	Sinus Pressure	Sneezing	Snoring
	Trouble Swallowing	Voice Change			
EYES	Discharge	Itching	Pain	Redness	Sensitivity to Light
	Visual Disturbance				
RESPIRATORY	Apnea	Chest Tightness	Choking	Cough	Shortness of Breath
	Voice Change	Wheezing			
CARDIOVASCULAR	Chest Pain	Leg Swelling	Palpitations		
GI	Abdominal Bloating	Abdominal Pain	Rectal Bleeding	Blood in Stool	Bowel Incontinence
	Constipation	Diarrhea	Nausea	Rectal Pain	Vomiting
ENDOCRINE	Cold Intolerance	Heat Intolerance	Excessive Thirst	Excessive Appetite	Urinary Frequency
GENITAL/URINARY	Bladder Incontinence	Breast Lump	Decreased Libido	Difficulty Urinating	Pain w/Intercourse
	Painful Urination	Increased Urinary Frequency		Enuresis	Flank Pain
	Frequency	Genital Sore	Hematuria	Menstrual Change	Nocturia
	Pelvic Pain	Sexual Difficulties	Urgency	Urine Decreased	Vaginal Bleeding
	Vaginal Discharge	Vaginal Pain			
MUSCULOSKELETAL	Joint Pain	Back Pain	Gait Problems	Joint Swelling	Myalgias
	Neck Pain	Neck Stiffness			
SKIN	Color Change	Hair Change	Hair Loss	Nail Change	Pallor
	Rash	Skin Change			
ALLERGY	Environmental Allergies		Food	Immunocompromised	
NEUROLOGICAL	Dizziness	Facial Asymmetry	Headaches	Light-headedness	Numbness
	Seizures	Speech Difficulty	Syncope	Tremors	Weakness
HEMATOLOGIC	Lymph Node Swelling	Bruise/Bleed Easily			
PSYCHIATRIC	Agitation	Behavior Problem	Confusion	Decreased Concentration	
	Depressed Mood	Dysphoric Mood	Hallucinations	Hyperactive	Nervous/Anxious
	Self-Injury	Severe Stress	Sleep Disturbance	Suicidal Ideas	
Mood Screen	Little interest or pleasure in doing things:		Not at all	Several Days	Nearly Every Day
	Feeling down, depressed, or hopeless:		Not at all	Several Days	Nearly Every Day