Baylor Scott & White
RESIDENCY
DALLAS

Adult Medical History

Name:_____ Today's Date: / ___/ ____
(Last) (First) (Middle)

Date of Birth: /_____/ _____ Age: _____ Referring Physician: _____

Primary Care Physician: _____
(Name) (Phone number)

Reason for Visit:

_____

PREFERRED PHARMACY:

NAME OF PHARMACY	ADDRESS AND PHONE NUMBER OF PHARMACY
LOCAL -	
MAIL ORDER -	

MEDICAL CONDITIONS: *Place X next to all that apply to you*

	Arthritis		Hepatitis		Skin Disease
	Asthma		Heart Disease		Thyroid Disease
	Anemia / Blood Disorder		High Blood Pressure		Urinary Incontinence
	Diabetes		Kidney Problems		Other:
	Gastric Reflux		Migraines		

SURGICAL HISTORY: *(ex, C-Section, D&Cs, Pelvic surgery, Appendectomy, Gall bladder removal, etc)*

TYPE OF SURGERY:	DATE OF SURGERY:	ANY COMPLICATIONS?

FAMILY MEDICAL HISTORY: Have any of your close relatives had the following?

	Condition	Relation	Maternal/ Paternal	Diag Age		Condition	Relation	Maternal/ Paternal	Diag Age
	Bleeding Disorder					High Blood Pressure			
	Breast Cancer					Diabetes			
	Ovarian Cancer					Stroke			
	Uterine Cancer					Other:			

PLEASE USE THE BACK OF THE FORM IF YOU NEED MORE SPACE

NAME:_____DATE OF BIRTH:_____/_____/_____

SOCIAL HISTORY:

EMPLOYER / POSITION:		
MARITAL STATUS: (Please Circle): Single / Married / Divorced / Separated / Widowed		
EXERCISE: _____times per week ACTIVITY:		
SEXUAL HISTORY (Please Circle): Satisfactory / Uncomfortable / Wish to Discuss		
CAFFEINE USE: YES / NO	TYPE	HOW OFTEN
ALCOHOL USE: YES / NO	TYPE	HOW OFTEN
ILLEGAL DRUGS USE: YES / NO	TYPE	HOW OFTEN
TOBACCO USE DO YOU SMOKE? YES / NO IF YES, PLEASE ANSWER THE FOLLOWING: How Many Packs Per Day Do You Smoke? How Many Years Have You Been Smoking?		HAVE YOU PREVIOUSLY SMOKED? YES/NO IF YOU ARE A FORMER SMOKER, PLEASE ANSWER THE FOLLOWING: What year did you quit smoking: How many years did you smoke: How many packs per day did you smoke:

ALLERGIES:

NAME OF MEDICATIONS / LATEX:	TYPE OF REACTION TO THE MEDICATIONS:

CURRENT MEDICATIONS
(PLEASE INCLUDE OVER THE COUNTER MEDICATIONS/VITAMINS/HERBALS):

MEDICATION NAME:	DOSAGE: (EX. 10MG)	HOW OFTEN: (Ex. Once a day, etc)

HEALTH MAINTENANCE / SCREENING:

	Date of last:		Date of last:		Date of last:		Date of last:
COLONOSCOPY		MAMMOGRAM		GARDASIL		TETANUS	
PAP SMEAR		BONE DENSITY		FLU VACCINE			

PLEASE NOTE THAT ALL HEALTH INFORMATION IS CONFIDENTIAL. WE WILL NOT RELEASE ANY INFORMATION WITHOUT YOUR SIGNED CONSENT. INFORMATION MAY BE RELEASED TO MEDICAL CONSULTANTS IF YOU ARE REFERRED.

NAME: _____ DATE OF BIRTH: _____ /_____ / _____

OBSTETRIC HISTORY:

TOTAL PREGNANCIES: _____ FULL TERM:_____ PRETERM: _____ MULTIPLE BIRTHS: _____ No. of INDUCED ABORTIONS:_____ MISCARRIAGES:_____ ECTOPICS: _____

	Year Delivered	Weeks Pregnant	Hours in Labor	Weight	Sex	Delivery Type	Hospital	Complications
1								
2								
3								
4								
5								
6								

GYNECOLOGIC HISTORY:

AGE OF FIRST PERIOD: _____
REGULAR CYCLES: YES / NO
CYCLE LENGTH (from start to start): ___
DURATION OF FLOW (# of days): _____
FLOW (light / med / heavy): _____
CRAMPS: None / Light / Moderate / Intense
MEDICATION FOR CRAMPS: _____
1st DAY OF LAST PERIOD:

PELVIC INFECTIONS:

Have You Been Diagnosed and/or Treated For:

Yeast	Trichimonas
Herpes	Syphilis
Chlamydia	Pelvic Inflammatory Disease
Gonorrhea	HIV

DATE OF LAST PAP SMEAR: _____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR: YES / NO
If yes, when:_____
Treatments:

ARE YOU SEXUALLY ACTIVE: YES / NO
SEXUAL ORIENTATION: Heterosexual / Homosexual / Bisexual / Transexual

CURRENT METHOD OF CONTRACEPTION: _____
HOW LONG HAVE YOU BEEN ON THIS METHOD:_____
WHAT CONTRACEPTION METHODS HAVE YOU TRIED BEFORE:
_____

REVIEW OF SYSTEMS: *Please circle any symptoms that you are CURRENTLY having:*

CONSTITUTIONAL Weight loss Weight gain Fever Fatigue	CARDIOVASCULAR Chest pain Swelling Palpitations	SKIN Breast discharge Breast lump Hair loss Rash Skin lesion	NEUROLOGIC Dizziness Numbness Trouble walking Headache Seizures
HEAD, EYES, EARS, NOSE, THROAT Ear pain or drainage Eye pain or drainage Hearing Loss Nasal drainage Sinus pressure Sore Throat Vision changes Ringing in ears	GASTROINTESTINA L Abdominal pain Blood in stools Constipation Diarrhea Heartburn Nausea Vomiting	MUSCULOSKELETA L Back pain Joint pain Joint swelling Muscle weakness Neck pain ENDOCRINE Cold intolerance Heat intolerance Abnormal thirst Abnormal hunger	Hematologic/Immunologic Easy bleeding Easy bruising Swollen lymph nodes Environmental/seasonal allergies Food allergies PSYCHIATRIC Anxiety Depression Insomnia
RESPIRATORY Chronic cough Cough Shortness of breath Wheezing	GENITOURINARY Pain with urination Blood in urine Urinary frequency Incontinence Incomplete emptying	REPRODUCTIVE Painful periods Painful intercourse Irregular periods Vaginal discharge	OTHER SYMPTOMS: