

Baylor Scott and White Family Medical Center at Baylor University Medical Center
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PAST MEDICAL HISTORY: Please check any of the following medical conditions you have had in the past.
 Please note date of onset/diagnosis: (Ex. Diabetes – 1979)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Gastro-Esophageal Reflux Disease | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Migraine Headaches | |

OTHER MEDICAL HISTORY List any other medical conditions you have been diagnosed with and the date of onset:

SURGICAL HISTORY List all surgeries with dates they occurred:

FAMILY HISTORY

RELATIONSHIP	LIVING?	PRESENT MEDICAL PROBLEMS / CAUSE OF DEATH
MOTHER/MATERNAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
FATHER/PATERNAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
SIBLINGS		
_____		_____
_____		_____
_____		_____
_____		_____

Please check box for any of the following medical conditions in your extended family members and indicated relation in brackets () Ex. Asthma (MATERNAL Aunt)

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis Family Medical |

PATIENT NAME: _____ DOB: _____

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SOCIAL HISTORY

OCCUPATION: _____

RELATIONSHIP STATUS: Single Married Widowed Divorced Common-Law Married Other

Do you think of yourself as:

gay, lesbian, or homosexual

straight or heterosexual

bisexual

Do you identify yourself as a transsexual or transgendered?

yes no

TOBACCO USE: Never Currently In the past (amount/day _____ # years used _____)

MEDICATIONS: (List ALL medications, prescribed and over the counter, herbs and supplements):

ALLERGIES TO MEDICATIONS: (List allergies to medications ONLY and the type of reaction to each):

Pharmacy: Phone number and cross street of pharmacy where we will send your medications now or in the future. Otherwise, you may have to return to pick up handwritten prescriptions if needed.

Pharmacy: _____ Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

PATIENT NAME: _____ DOB: _____