Baylor Scott & White Family Medicine Weatherford

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Name: _____ DOB: _____ Marital Status: _____

Occupation: _____ Number of Children: _____

Medications:

Medication Name	Dose	How often

Personal Medical History:

Please indicate whether you have had any of the following medical problems:

___ Abnormal Pap
___ Anemia
___ Anxiety
___ Asthma
___ Atrial Fibrillation
___ Congestive Heart Failure
___ COPD
___ Depression
___ Diabetes
___ GERD
___ GI Bleed
___ Heart attack
___ Heart disease
___ Hepatitis
___ High Cholesterol
___ Hypertension
___ Hypothyroid
___ Osteoporosis
___ Seizure Disorder
___ Stroke
___ Cancer (specify)_____

Other medical problems not listed above: _____

Past Surgical History: (Please indicate date)

___ Appendectomy
___ Back Surgery
___ Breast Augmentation
___ Breast Reduction
___ CABG
___ Cataract
___ C-Section
___ Gallbladder
___ Hernia
___ Hip Replacement
___ Hysterectomy
___ Hysterectomy w/BSO
___ Knee Arthroscopy/scope
___ Knee Replacement
___ Mastectomy
___ Shoulder Surgery
___ Tonsillectomy
___ Transplant (specify) _____
___ Tubal Ligation
___ Vasectomy
___ No Surgeries

Other surgeries not listed above: _____

Family History:

Father's age _____ If deceased, age at death and cause _____

Mother's age _____ If deceased, age at death and cause _____

Diagnosis	Family Member	Diagnosis	Family Member
Anemia		Heart Disease	
Anxiety/Depression		Migraine	
Blood Clots		Osteoporosis	
Diabetes		Stroke	
Cancer		Thyroid disease	

Other: _____ Negative Family History: ___

Social History:

Smoker _____ Packs daily _____ How long? _____ Interested in quitting? _____

Chewing Tobacco _____ Amount _____ How long? _____ Interested in quitting? _____

Alcohol _____ Type _____ Amount _____ How often? _____

Recreational Drugs _____ Type _____ How often? _____

Exercise _____ Type _____ How often? _____

Preventative Healthcare: (Please indicate date and results)

Test/Procedure	Date	Results
Pap Smear		
Mammogram		
Colonoscopy		
PSA		
Lab Work		
Tetanus Vaccine		

Review of Systems: Please circle symptoms you are ***currently*** experiencing.

General:
Weight loss Fatigue Fever Chills Weakness Trouble sleeping

Skin:
Rashes Lumps Itching Dryness Color changes Hair and nail changes Yellow eyes or skin

Ears:
Decreased hearing Ringing in ears Earache Drainage

Eyes:
Pain Redness Blurry/double vision Lights Dryness Spots

Nose:
Stuffiness Drainage Sneezing Itching Hay fever Nosebleeds Sinus pain

Throat:
Dry mouth Sore throat Hoarseness Snoring

Mouth:
Non-healing sores Sore tongue bleeding gums

Neck:
Lumps Swollen glands Pain Stiffness

Breasts:
Lumps Pain Warm to the touch Discharge Skin changes

Respiratory:
Cough (dry/wet/productive) Sputum (color/consistency) Coughing up blood Shortness of breath Wheezing Painful breathing

Cardiovascular:
Chest pain or discomfort Tightness Palpitations Shortness of breath with activity Difficulty breathing lying down Swelling of feet/legs

Gastrointestinal:
Swallowing difficulties Heartburn Change in appetite Change in bowel habits Rectal bleeding Nausea/Vomiting Constipation Diarrhea Abdominal Pain Black/tarry stools

Urinary:
Frequency Urgency Burning or pain Blood in urine Incontinence Change in urinary strength

Genital:
Male: Pain with sex Hernia Penile discharge Sores Masses or pain Erectile dysfunction STDs Infertility
Female: Pain with sex Vaginal Dryness Hot flashes Vaginal discharge Itching or Rash STDs Infertility

Vascular:
Calf pain with walking Leg cramping Legs swollen at the end of day Legs heavy Popping veins in legs

Musculoskeletal:
Muscle or joint pain stiffness Back pain Redness of joints Swelling of joints Trauma Redness in joints

Neurologic/Head:
Headache Head injury Dizziness Fainting Seizures Weakness Numbness Tingling Tremor

Hematologic:
Bruising easily Bleeding easily

Endocrine:
Heat or cold intolerance Sweating Frequent urination Increased Thirst Decreased/increased appetite

Psychiatric:
Depression Memory Loss Stress Anxiety