

A Baylor-HealthTexas Affiliate

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Welcome to our practice! We are happy you chose HealthTexas Provider Network and Baylor Health Care System for your health care needs. We would appreciate your assistance by completing both sides of this form. This is confidential information, and will be kept in your electronic medical record.

Please describe your present illness or the reason for your visit today: (Include symptoms and the date of their onset)

Past Medical History: (Put a check next to any problems you have had. If unsure, you may leave it blank)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Anemia*(low blood count) | <input type="checkbox"/> Diabetes-Gestational* | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes-Type 1 | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes-Type 2 | <input type="checkbox"/> Hyperthyroidism(Overactive) | <input type="checkbox"/> Skin Cancer* |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diverticulosis* | <input type="checkbox"/> Hypothyroidism(Underactive) | <input type="checkbox"/> Substance abuse* |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> DVT (blood clot leg) | <input type="checkbox"/> Hypothyroidism(Underactive) | <input type="checkbox"/> Thyroid Disorder* |
| <input type="checkbox"/> Blood transfusion* | <input type="checkbox"/> Dyslipidemia (Cholesterol Problems) | <input type="checkbox"/> Kidney Stones* | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Emphysema* | <input type="checkbox"/> Liver Disease* | <input type="checkbox"/> Recurrent Urinary Infection* |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Myocardial Infarction(Heart Attack) | <input type="checkbox"/> Varicose Veins/Phlebitis* |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other Problems (Not Listed) |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Gout* | <input type="checkbox"/> Osteoporosis (thin bone) | Describe: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GI Bleed*(Stomach Bleeding) | <input type="checkbox"/> Peptic Ulcer Disease | _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart-ASCVD*(Heart Disease) | <input type="checkbox"/> Peripheral Vascular Disease | _____ |
| <input type="checkbox"/> CVA/Stroke* | <input type="checkbox"/> Heart-CHF*(Heart Failure) | <input type="checkbox"/> Kidney Failure | _____ |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Heart-Valvular* | | _____ |
| | <input type="checkbox"/> Hepatitis A* | | _____ |

Past Surgical History and Any Hospitalizations: (Please list any dates of occurrence, if known)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Unremarkable* | <input type="checkbox"/> Carpal Tunnel* | <input type="checkbox"/> Hysterectomy & Ovaries Removed | <input type="checkbox"/> Transplant Heart |
| <input type="checkbox"/> Abdominal Surgery* | <input type="checkbox"/> CABG (Heart Bypass) | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Transplant Liver |
| <input type="checkbox"/> Aneurysm Repair* | <input type="checkbox"/> Carotid Endarterectomy* | <input type="checkbox"/> Knee Replacement* | <input type="checkbox"/> Transplant Lung |
| <input type="checkbox"/> Appendectomy* | <input type="checkbox"/> Cataract Extraction* | <input type="checkbox"/> Lumbar Disectomy* | <input type="checkbox"/> Transplant Kidney |
| <input type="checkbox"/> Left Aortic-Femoral Bypass* | <input type="checkbox"/> C-Section* | <input type="checkbox"/> Mastectomy* | <input type="checkbox"/> Sinus Surgery* |
| <input type="checkbox"/> Right Aortic-Femoral Bypass* | <input type="checkbox"/> Cervical Discectomy*(Neck) | <input type="checkbox"/> Mitral Valve Replace | <input type="checkbox"/> Uterus/Ovary Surg* |
| <input type="checkbox"/> Bilateral Aortic-Femoral Bypass* | <input type="checkbox"/> Cholecystectomy*(Gallbladder) | <input type="checkbox"/> Kidney Removal* | <input type="checkbox"/> Surgical Complications (No) |
| <input type="checkbox"/> Aortic Valve Replacement* | <input type="checkbox"/> Colon Resection* | <input type="checkbox"/> Heart Angioplasty | <input type="checkbox"/> Surgical Complications (Yes) |
| <input type="checkbox"/> Breast Augmentation* | <input type="checkbox"/> Craniotomy*(Brain) | <input type="checkbox"/> Lung Removal* | <input type="checkbox"/> Anesthesia Problems (No) |
| <input type="checkbox"/> Breast Biopsy* | <input type="checkbox"/> Gastric Lap Band | <input type="checkbox"/> Shoulder Repair* | <input type="checkbox"/> Anesthesia Problems (Yes) |
| <input type="checkbox"/> Breast Lumpectomy* | <input type="checkbox"/> GYN Surgery* | <input type="checkbox"/> Stomach Bypass | <input type="checkbox"/> Other Problems Not Listed: |
| <input type="checkbox"/> Breast Reduction* | <input type="checkbox"/> Hernia Repair Inguinal* | <input type="checkbox"/> Tonsillectomy* | Please describe: _____ |
| <input type="checkbox"/> Breast Surgery* | <input type="checkbox"/> Hernia Repair Umbilical* | <input type="checkbox"/> Tubal Ligation* | _____ |
| <input type="checkbox"/> Bronchoscopy*(Lung) | <input type="checkbox"/> Hip Replacement* | | _____ |
| <input type="checkbox"/> Cardiac Cath(Heart) | <input type="checkbox"/> Hysterectomy* | | _____ |

Family History: Please **Circle** any family members with a history of **Alcoholism, Allergies, Anxiety, Asthma, Blood Clots, Breast Cancer, Cervical Cancer, Colon Polyps, Depression, Diabetes, High Cholesterol, Heart Disease, High Blood Pressure, Liver Disease, Lung Cancer, Melanoma, Migraine, Osteoporosis, Seizures, Stroke.**

	<u>Age:</u>	<u>Health Problems:</u>	<u>Age of death:</u>	<u>Cause:</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Aunts	_____	_____	_____	_____
Uncles	_____	_____	_____	_____
Other	_____	_____	_____	_____
Any other family members we should know about?	_____	_____	_____	_____

PLEASE COMPLETE SIDE TWO (OVER)

Social History & Risk Factors:

Marital Status: **(Circle One)** Single Married Divorced Widowed Children: **(Circle One)** Yes No
 Occupation: _____ Home Health Agency Name: _____

Risk Factors:

Tobacco Use: ___ Current Every Day Smoker ___ Current Some Days Smoker ___ Former Smoker ___ Never Smoker
 Passive Smoke: ___ Yes ___ No Drug Use ___ Yes ___ No If Yes, Substance _____
 Caffeine Use: Drinks per day? _____ How many hours per week do you exercise? _____
 Family History Heart Attack in Female Age < 65 ___ Yes ___ No
 Family History Heart Attack in Male Age < 55 ___ Yes ___ No
 Alcohol Use: ___ Yes ___ No If Yes, Drinks per day _____ Most common type consumed _____

Prevention:

Date of Last Colonoscopy _____ **Women:** Date Last Mammogram: _____
 Date of Last Pap Smear: _____

Review of Systems:

General:

___ Appetite Loss
 ___ Dizziness
 ___ Fatigue (Tired)
 ___ Fever
 ___ Generalized Weakness
 ___ Unintentional Weight Loss

Eyes:

___ Discharge
 ___ Halos
 ___ Irritation
 ___ Recent Visual Changes

Ears, Nose, Throat:

___ Allergy/Sinus Problems
 ___ Difficulty Swallowing
 ___ Disruptive Snoring
 ___ Ear Ache
 ___ Hearing Loss Affecting Daily Function
 ___ Nasal Congestion
 ___ Post Nasal Drip
 ___ Runny Nose
 ___ Sneezing
 ___ Voice Change

Cardiovascular:

___ Chest Pain or Discomfort
 ___ Pain Legs Walking
 ___ Palpitations/Irregular Heart Beat
 ___ Swelling Hands or Feet
 ___ Pass Out

Respiratory:

___ Chest Congestion
 ___ Cough
 ___ Cough Up Blood
 ___ Shortness of Breath
 ___ Sleep Disturbance Due Breathing
 ___ Wheezing

Gastrointestinal:

___ Abdominal Bloating
 ___ Abdominal Pain
 ___ Change in Bowel Movements
 ___ Difficulty Swallowing
 ___ Constipation
 ___ Diarrhea
 ___ Heart Burn/Indigestion
 ___ Blood in Stool
 ___ Nausea
 ___ Rectal Bleeding
 ___ Throw Up (Vomiting)

Genitourinary:

___ Breast Pain
 ___ Decreased Libido (adults)
 ___ Pain with Urination
 ___ Blood in Urine
 ___ Urine Loss
 ___ Menstrual Irregularity
 ___ Nipple Discharge
 ___ Pelvic Pain
 ___ Urinary Frequency
 ___ Urinary Urgency
 ___ Vaginal Discharge

Musculoskeletal:

___ Back Pain
 ___ Joint Pain
 ___ Joint Swelling
 ___ Muscle Aches

Dermatology:

___ Acne
 ___ Hair Loss
 ___ Nail Problems
 ___ Pruritis
 ___ Rash
 ___ Suspicious Skin Mole

Neurology:

___ Ataxia
 ___ Burning Pain Feet
 ___ Double Vision
 ___ Frequent Falls
 ___ Headaches
 ___ Muscle Weakness
 ___ Numbness
 ___ Seizures
 ___ Sudden Loss Vision
 ___ Tremors

Psychological:

___ Anxiety
 ___ Depression
 ___ Unable to Sleep

Endocrinology:

___ Excessive Thirst
 ___ Excessive Urination
 ___ Temperature Intolerance

Hematology:

___ Abnormal Bleeding
 ___ Bruises Easily
 ___ Enlarged Lymph Nodes

Allergy:

___ Eye Itching
 ___ Hives
 ___ Recurrent Infection
 ___ Seasonal Allergies

Prevention and Screening: ("When was your last..." If unknown, leave blank.)

Female:

Pap smear? _____
 Mammogram? _____
 Breast Exam? _____
 Bone Density? _____

Male:

Prostate Exam? _____
 PSA Screening? _____

General:

Stool test for blood? _____
 Colonoscopy? _____
 Chest X-ray? _____
 Tuberculosis test? _____
 Tetanus shot? _____
 Pneumonia Shot? _____
 Flu Shot? _____

Hepatitis A or B shot? _____

EKG or Stress Test? _____

Cholesterol Test? _____

Diabetic:

A1C Test? _____
 Urine Protein? _____
 Eye exam? _____
 Who is your Ophthalmologist? _____

Please Sign: _____ Date: _____

PLEASE COMPLETE SIDE ONE (OVER)

