Baylor Scott & White
FAMILY MEDICINE
PROSPER
A member of HealthTexas Provider Network

Name:

DOB:

Date:

Thank you for choosing Baylor Scott & White Family Medicine – Prosper. 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 Allergies

Allergy	Reaction type

Medications:

List any medications you take, prescription and nonprescription and their dosage: ☐None

Medication	Dose	Refill Needed (Y/N)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Past Medical History: Please check all that apply

	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
	Hyperlipidemia

	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

	Abdominal aneurysm
	Appendectomy
	Back surgery
	Bariatric surgery
	Brian surgery
	Breast biopsy R/L
	Breast enhancement
	CABG-Heart bypass
	Cardiac catheterization
	Carotid endarterectomy
	Carpal tunnel surgery R/L
	Cataract surgery R/L

	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
	Knee surgery R/L

	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
	Other:

Family History: Please check all that apply

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

Cancer

List any type of cancer you have or have had

Type of	Age of diagnosis

Social History:

Alcohol Use: ☐ Yes ☐ No

Number of drinks per 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: If so what type

☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes ☐ Snuff ☐ Chew

Year started _____ Packs/day _____ Quit Date _____

Occupation: _____

Depression Screen: 0-3

_____Little interest or pleasure in doing things _____Feeling down, depressed or hopeless

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:_____
Prevnar:_____
Zostavax/Shingles Vaccination:_____
Human Papilloma Vaccination (HPV)/Gardasil:_____
Pneumovax:_____
Influenza vaccination:_____

Preventive 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		