## 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:**

| **Medication or Food** | **Reaction** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**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:_____

**Are you pregnant _____**

**LMP Start date _____**

**Past Surgical History:** (Please indicate date)

___ Appendectomy
___ Gallbladder
___ Mastectomy

___ Back Surgery
___ Breast Augmentation
___ Breast Reduction
___ CABG
___ Cataract
___ C-Section
___ Hernia
___ Hip Replacement
___ Hysterectomy
___ Hysterectomy w/BSO
___ Knee Arthroscopy/scope
___ Knee Replacement
___ 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/Vomiti ng 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 F emale: 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