



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"/> Kidney Stones* | <input type="checkbox"/> Thyroid Disorder* |
| <input type="checkbox"/> Blood transfusion* | <input type="checkbox"/> Dyslipidemia (Cholesterol Problems) | <input type="checkbox"/> Liver Disease* | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Emphysema* | <input type="checkbox"/> Myocardial Infarction(Heart Attack) | <input type="checkbox"/> Recurrent Urinary Infection* |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Varicose Veins/Phlebitis* |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis (thin bone) | <input type="checkbox"/> Other Problems (Not Listed) |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Gout* | <input type="checkbox"/> Peptic Ulcer Disease | Describe: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GI Bleed*(Stomach Bleeding) | <input type="checkbox"/> Peripheral Vascular Disease | _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart-ASCVD*(Heart Disease) | <input type="checkbox"/> Kidney Failure | _____ |
| <input type="checkbox"/> CVA/Stroke* | <input type="checkbox"/> Heart-CHF*(Heart 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 Disectomy*(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: _____

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

Female:	General:	Hepatitis A or B shot? _____	Diabetic:
Pap smear? _____	Stool test for blood? _____	Mammogram? _____	A1C Test? _____
_____	Colonoscopy? _____	EKG or Stress Test? _____	Urine Protein? _____
Breast Exam? _____	Chest X-ray? _____	_____	Eye exam? _____
Bone Density? _____	Tuberculosis test? _____	Cholesterol Test? _____	Who is your Ophthalmologist? _____
Male:	Tetanus shot? _____		
Prostate Exam? _____	Pneumonia Shot? _____		
PSA Screening? _____	Flu Shot? _____		

ALLERGIES:

Medication List

NAME:
DATE:

DOB:

LIST ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS WITH DOSES YOU ARE CURRENTLY USING

MEDICATION NAME / DOSE / FREQUENCY

Please Sign: _____ **Date:** _____