BaylorScott&White
PRIMARY CARE
AT THE STAR
A member of HealthTexas Provider Network

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

___Abnormal Pap Smear
___Anemia*(low blood count)
___Anxiety
___Asthma
___Atrial Fibrillation
___Bipolar Disorder
___Blood transfusion*
___Breast Cancer
___Cervical Cancer
___Chronic Back Pain
___Colon Cancer
___COPD
___Crohn's Disease
___CVA/Stroke*
___Dementia
___Depression
___Diabetes-Gestational*
___Diabetes-Type 1
___Diabetes-Type 2
___Diverticulosis*
___DVT (blood clot leg)
___Dyslipidemia (Cholesterol Problems)
___Emphysema*
___Fibrocystic Breast Disease
___GERD
___Gout*
___GI Bleed*(Stomach Bleeding)
___Heart-ASCVD*(Heart Disease)
___Heart-CHF*(Heart Failure)
___Heart-Valvular*
___Hepatitis A*
___Hepatitis B
___Hepatitis C
___Hypertension (High Blood Pressure)
___Hyperthyroidism(Overactive)
___Hypothyroidism(Underactive)
___Kidney Stones*
___Liver Disease*
___Myocardial Infarction(Heart Attack)
___Osteoarthritis
___Osteoporosis (thin bone)
___Peptic Ulcer Disease
___Peripheral Vascular Disease
___Kidney Failure
___Renal Insufficiency
___Rheumatoid Arthritis
___Seizure Disorder
___Skin Cancer*
___Substance abuse*
___Thyroid Disorder*
___Tuberculosis
___Recurrent Urinary Infection*
___Varicose Veins/Phlebitis*
___Other Problems (Not Listed)
Describe:
_____
_____
_____
_____
_____

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

___Unremarkable*
___Abdominal Surgery*
___Aneurysm Repair*
___Appendectomy*
___ Left Aortic-Femoral Bypass*
___ Right Aortic-Femoral Bypass*
___Bilateral Aortic-Femoral Bypass*
___Aortic Valve Replacement*
___Breast Augmentation*
___Breast Biopsy*
___Breast Lumpectomy*
___Breast Reduction*
___Breast Surgery*
___Bronchoscopy*(Lung)
___Cardiac Cath(Heart)
___ Carpal Tunnel*
___ CABG (Heart Bypass)
___Carotid Endarterectomy*
___Cataract Extraction*
___C-Section*
___Cervical Discectomy*(Neck)
___Cholecystectomy*(Gallbladder)
___Colon Resection*
___Craniotomy*(Brain)
___Gastric Lap Band
___GYN Surgery*
___Hernia Repair Inguinal*
___Hernia Repair Umbilical*
___Hip Replacement*
___Hysterectomy*
___ Hysterectomy & Ovaries Removed
___ Knee Arthroscopy
___ Knee Replacement*
___Lumbar Disectomy*
___ Mastectomy*
___ Mitral Valve Replace
___ Kidney Removal*
___ Heart Angioplasty
___ Lung Removal*
___ Shoulder Repair*
___ Stomach Bypass
___ Tonsillectomy*
___ Tubal Ligation*
___ Transplant Heart
___ Transplant Liver
___ Transplant Lung
___ Transplant Kidney
___ Sinus Surgery*
___ Uterus/Ovary Surg*
___ Surgical Complications (No)
___ Surgical Complications (Yes)
___ Anesthesia Problems (No)
___ Anesthesia Problems (Yes)
___ Other Problems Not Listed:
Please describe:
_____
_____

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.**

	Age:	Health Problems:	Age of death:	Cause:
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)

ALLERGIES:

Medication List

NAME: **DOB:** **DATE:**

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

MEDICATION NAME / DOSE / FREQUENCY