Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Name:
DOB:
Date:

Thank you for choosing Baylor Scott & White - HealthTexas Provider Network. 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
1.		
2.		

Medications

List any medications you take, prescription and nonprescription and their dosage: ☐ No medications

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

Local Pharmacy: _____ **Phone Number: _____**

Address: _____ **City: _____**

Mail order Pharmacy: _____

Past Medical History: Please check all that apply. ☐ No medical problems

	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

	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: ☐ No surgeries

	Abdominal aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Brain Surgery
	Breast Biopsy R/L
	Breast Enhancement
	Breast Surgery R/L
	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
	Masectomy (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	Asthma	Autoimmune	Breast cancer	Cancer	Colon Cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

Alcohol Use: ☐ Yes ☐ No

Number of drinks/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: ☐ Yes ☐ No

If so what type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes ☐ Snuff ☐ Chew

Year Started_____ Packs/day_____ Quit Date_____

Occupation:_____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children: _____

Years of education: _____

Who do you live with?_____

Immunizations: Please enter the dates of your most recent vaccinations

Tetanus/TdaP/Td: _____ **Human Papilloma Vaccination (HPV)/Gardasil:_____**

Prevnar:_____ **Pneumovax:_____**

Zostavax /Shingles Vaccination:_____ **Influenza Vaccination_____**

Preventative 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		

For Women Only

OB/Gyn History:

Last Menstrual period:

Duration of periods: Interval between periods: Heavy periods: **:** ☐ Yes ☐ No

# of pregnancies:_____ # of miscarriages:_____ # of abortions:_____

Have you had any of these symptoms in the last 2 weeks

Constitution		
yes	Activity Charge	no
yes	Appetite Change	no
yes	Chills	no
yes	Diaphoresis	no
yes	Fatigue	no
yes	Fever	no
yes	Unexpected Weight Change	no

HENT		
yes	Congestion	no
yes	Dental Problem	no
yes	Drooling	no
yes	Ear Discharge	no
yes	Ear Pain	no
yes	Facial Swelling	no
yes	Hearing Loss	no
yes	Mouth Sores	no
yes	Nosebleeds	no
yes	Postnasal Drip	no
yes	Rhinorrhea	no
yes	Sinus Pressure	no
yes	Sneezing	no
yes	Sore Throat	no
yes	Tinnitus	no
yes	Trouble Swallowing	no
yes	Voice Change	no

Eyes		
yes	Eye Discharge	no
yes	Eye Itching	no
yes	Eye Pain	no
yes	Eye Redness	no
yes	Photophobia	no
yes	Visual Disturbance	no

Respiratory		
yes	Apnea	no
yes	Chest Tightness	no
yes	Choking	no
yes	Cough	no
yes	Shortness of Breath	no
yes	Stridor	no
yes	Wheezing	no

Cardiovascular		
yes	Chest Pain	no
yes	Leg Swelling	no
yes	Palitations	no

GI		
yes	Abdominal Distention	no
yes	Abdominal Pain	no
yes	Anal Bleeding	no
yes	Blood in Stool	no
yes	Constipations	no
yes	Diarrhea	no
yes	Nausea	no
yes	Rectal Pain	no
yes	Vomiting	no

Endocrine		
yes	Cold Intolerance	no
yes	Heat Intolerance	no
yes	Polydipsia	no
yes	Polyphagia	no
yes	Polyuria	no

GU		
yes	Difficulty Urinating	no
yes	Dyspareunia	no
yes	Dysuria	no
yes	Enuresis	no
yes	Flank Pain	no
yes	Frequency	no
yes	Gential Sore	no
yes	Hematuria	no
yes	Menstrual Problem	no
yes	Pelvic Pain	no
yes	Urgency	no
yes	Urine Decreased	no
yes	Vaginal Bleeding	no
yes	Vaginal Discharge	no
yes	Vaginal Pain	no

Muscular		
yes	Arthralgias	no
yes	Back Pain	no
yes	Gait Problem	no
yes	Joint Swelling	no
yes	Myalgias	no
yes	Neck Pain	no
yes	Neck Stiffness	no

SKIN		
yes	Color change	no
yes	Pallor	no
yes	Rash	no
yes	Wound	no

Allergy/Immunology		
yes	Environmental Allergies	no
yes	Food Allergies	no
yes	Immunocompromised	no

Neurological		
yes	Dizziness	no
yes	Facial Asymmetry	no
yes	Headaches	no
yes	Light-Headedness	no
yes	Numbness	no
yes	Seizures	no
yes	Speech Difficulty	no
yes	Syncope	no
yes	Tremors	no
yes	Weakness	no

Hematologic		
yes	Adenopathy	no
yes	Bruises easily	no

Psychiatric		
yes	Agitation	no
yes	Behavior Problem	no
yes	Confusion	no
yes	Decreased Concentration	no
yes	Dysphoric Mood	no
yes	Hallucinations	no
yes	Hyperactive	no
yes	Nervous/anxious	no
yes	Self-injury	no
yes	Sleep Disturbance	no
yes	Suicidal Ideas	no