Name:

DOB:

Date:

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:_____

Home Health Company: _____ Phone # _____

<u>Advance Directive</u>

Do you have advance directive? Yes _____ No _____

Please Specify _____

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

	Anemia		GI Bleed		Myocardial Infarction
	Anxiety		Gout		Prostate Cancer
	Asthma		Hepatitis A		Renal Failure
	Atrial fibrillation		Hepatitis B		Seizures
	Chicken Pox		Hepatitis C		Skin Cancer
	Chronic back pain		High blood pressure / HTN		Stroke
	Colon Cancer		Hyperthyroidism		Substance abuse
	Deep Vein Thrombosis		Hypothyroidism		Ulcers
	Depression		Kidney Stones		
	GERD				

Additional History

Surgical History: Please Check all that apply: ☐ **No surgeries**

	Abdominal aneurysm		Cholecystectomy		Lung Transplant
	Appendectomy		Colon Surgery		Masectomy (breast removal) R/L
	Back Surgery		Femoral Popliteal Bypass		Neck Surgery
	Bariatric Surgery		Heart Transplant		Pneumonectomy
	Brain Surgery		Hip Surgery R/L		Prostate Surgery
	Breast Biopsy R/L		Hysterectomy		Shoulder Surgery R/L
	Breast Enhancement		Hysterectomy with ovaries removed		Sinus Surgery
	Breast Surgery R/L		Kidney removal R/L		Tonsillectomy
	CABG-Heart bypass		Kidney Transplant		Tubal ligation (tubes tied)
	Cardiac Catheterization		Knee arthroscopy		Valve replacement
	Carotid Endarterectomy		Knee Surgery R/L		Vasectomy
	Carpal Tunnel Surgery R/L		Liver Transplant		Other:
	Cataract Surgery R/L				
	Cerebral Aneurysm				

Additional History _____

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:																						

If family history not listed above, please list below

Relative	Condition	Age of Onset

Social History:

Alcohol Use: ☐ Yes ☐ No

Number of drinks/week: ____ glasses of wine ____ cans of beer ____ shots of liquor

Alcohol / Week _____ Comments: _____

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?_____

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

Immunization	Yes/No	If YES, DATE
Tetanus/TdaP/Td		
Prevnar 13		
Pneumovax		
Zostavax/Shingles		
Influenza/ Flu		
HPV/Gardasil		

Preventative care: Please enter the dates of your most recent tests

	Date	Result
Last Physical		
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		

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

CANCELLATION POLICY

We regret the need to implement the policy below, but we have had an increasing number of patients who fail to keep their scheduled appointments. As a courtesy, we agree to confirm your appointment by an automated reminder call to your primary phone number two days before your scheduled appointment. You will at that time have the opportunity to cancel, confirm, or submit a request to have someone from the office contact you to re-schedule. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not canceling their scheduled appointment is that the physicians are then unable to accommodate those patients with sudden medical problems that require medical intervention.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment at Baylor Family Medicine at Aubrey.

The fee will be $25.00 for a regular office visit and $50.00 for annual physicals or well-child exams payable by statement or at my next scheduled visit. I understand that this fee is not reimbursable by my insurance carrier.

_____ _____

Patient Signature Date

LATE SHOW POLICY

Our providers do their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment as a “work in” appointment as the schedule allows. The policy is that new patients arrive 30 minutes prior to their scheduled appointment time and established patients arrive 5 minutes before their scheduled appointment time.

I hereby acknowledge and accept the above policy.

_____ _____

Patient Signature Date

PHONE CALL POLICY

The practice policy is to return phone messages left before 11:30, will be returned by 1:30. Messages left after 11:30, but before 4:00, will be returned by the end of that business day. Messages left after 4:00, will be returned by 1:30 the following business day. _____

Initials