Baylor Community Care at Fort Worth

Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details. Thank you!

Name:_____DOB:_____Marital Status:_____

Occupation: _____Number of children:_____

Personal medical history:

Please indicate whether you have had any of the following medical problems:

____Congenital heart disease	____Congestive heart failure	____Abnormal Pap
____Heart attack	____Anemia	____Depression
____Hypertension	____Asthma	____Anxiety
____Diabetes	____Atrial fibrillation	____Alcoholism
____High cholesterol	____COPD	____Renal disease
____Stroke	____GERD	____Seizure Disorder
____Thyroid disorder *specify type*_____	____Hepatitis *specify type*_____	____Headaches

Other medical problems not listed above: _____

Medications

Name	Dose	How often

Allergies or Reactions to medications: _____

Surgical History (Please list all prior operations and dates):

Habits:

Smoker_____Packs daily_____How long?_____Interested in quitting?_____
Exercise_____Type_____How often_____
Daily caffeine intake (cups)_____
Alcohol_____Type_____Amount_____How often_____
Recreational drugs_____Type_____How often_____

Preventative Health Care (Please indicate the date and results)

Test	*Date*	*Results (if indicated)*
Pap smear		
Mammogram		
Colonoscopy		
PSA		
Lab Work		
Tetanus vaccine		

Family History:

Father's age_____ If deceased, age at death and cause_____
Mother's age_____ If deceased, age at death and cause_____
Total number of brother's or sister's_____ Living_____

Diagnosis	*Family member*	*Diagnosis*	*Family member*
Hypertension		Osteoporosis	
Diabetes		Bleeding disorder	
Stroke		Glaucoma	
Cancer		Depression/Anxiety	
Heart disease		Alcoholism	
Thyroid disease		Migraines	