Baylor Scott & White
PRIMARY CARE
CASTLE HILLS
A member of HealthTexas Provider Network

Name: _____

DOB: _____

Date: _____

MRN#: _____

Thank you for choosing Baylor Scott & White Primary Care Castle Hills. 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(s) for your visit today? _____

Allergies - List any significant reactions to food or medications below

Allergic to	**Allergic to**

Medications - List any medications you take, prescription and other-the-counter along with the doses

Medication	**Dose**	**Refill Needed (Y/N)?**

Pharmacy – List your local and mail order pharmacy information

	Name and address	**Phone #**
Local		
Mail Order		

Your Care Team – List include the names and specialties of all providers you currently see

Provider Name and Specialty	Phone #

Past Medical History – Check all that apply ☐ No medical problems

☐	Abnormal pap smear	☐	Depression	☐	Hypothyroidism
☐	Anemia	☐	GERD/Reflux	☐	Kidney Stone
☐	Anxiety	☐	Gestational Diabetes	☐	Heart Attack
☐	Asthma	☐	GI Bleed	☐	Kidney Failure
☐	Atrial Fibrillation	☐	Gout	☐	Kidney Disease
☐	Breast Cancer	☐	Hepatitis A	☐	Seizures
☐	Cervical Cancer	☐	Hepatitis B	☐	Skin Cancer
☐	Chicken Pox	☐	Hepatitis C	☐	Stroke
☐	Chronic Back Pain	☐	Hypertension	☐	Substance Abuse
☐	Colon Cancer	☐	Hyperthyroidism	☐	Ulcers
☐	Deep Vein Thrombosis				

Additional history you feel would be valuable for me to be aware of: _____

_____

Past Surgical History – Check all that apply ☐ No medical problems

☐	Abdominal Aneurysm	☐	Cataract Surgery L/R	☐	Liver Transplant
☐	Appendectomy	☐	Cerebral Aneurysm	☐	Lung Transplant
☐	Back Surgery	☐	Gallbladder Removal	☐	Mastectomy R/L/Both
☐	Bariatric Surgery	☐	Colon Surgery	☐	Neck Surgery
☐	Brain Surgery	☐	Heart Transplant	☐	Previous C-Section
☐	Breast Biopsy L/R	☐	Hip Surgery R/L/Both	☐	Shoulder Surgery R/L
☐	Breast Enhancement	☐	**Hysterectomy**	☐	Sinus Surgery
☐	Breast Surgery L/R	☐	**Hysterectomy w/ovaries removed**	☐	Tonsillectomy
☐	CABG – Heart Bypass	☐	Kidney Removal L/R	☐	Tubal Ligation (tubes tied)
☐	Cardiac Catheterization	☐	Kidney Removal L/R	☐	Valve Replacement
☐	Carotid Endarectomy	☐	Kidney Transplant	Other	
☐	Carpal Tunnel Surgery L/R	☐	Knee Arthroscopy		
		☐	Knee Surgery L/R		

Family History – 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

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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 Cigarette ☐ Snuff ☐ Chew

Year Started: Packs/Day: Quit Date:

Occupation:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Number of Children:

Year of Education:

Who do you live with?

OB/GYN History

Last Menstrual Period: _____

Duration of Period: _____ Interval between periods: _____ Heavy Periods: ◯Yes ◯No

# of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____

Immunizations – Enter the dates of your most recent vaccinations

Influenza (yearly)		Human Papilloma Vaccination (HPV/Gardasil):	
Tetanus/TdaP/Td:		Pneumovax:	
Shingrix – Dose #1		Prevnar:	
Shingrix – Dose #2		Zostavax:	

Preventative Care – Enter the dates of your most recent test results.

	Date	**Result**	**Provider/Facility**
Colonoscopy			
Sigmoidoscopy			
Cologuard			
Hemoccult			
Osteoporosis/DEXA			
For Women Only			
Pap Smear			
Mammogram			
Breast Exam			
For Men Only			
Last Prostrate Exam			
PSA			

Advanced Directives

Do you have a living will?	Yes	No
Do you have a Medical Power of Attorney?	Yes	No
Do you have an out of hospital "Do Not Resuscitate" (DNR)?	Yes	No
If you answered **YES** to any of these questions, please bring a copy of the legal document to your first visit.		
If you answered **NO**, we have information that will be provided for you to discuss with your family so that Advanced Medical Directives can be incorporated into your medical chart.		

Constitutional	Activity Change	Appetite Change	Chills	Chronic Pain	Daytime Sleepiness
	Excessive Sweating	Fatigue	Fever	Unexpected Weight Change	
HENT	Congestion	Dental Problems	Drooling	Ear Pain	Facial Swelling
	Hearing Loss	Mouth Sores	Nosebleeds	Post Nasal Drip	Reflux
	Runny Nose	Sinus Pain	Sinus Pressure	Sneezing	Snoring
	Trouble Swallowing	Voice Change			
Eyes	Discharge	Itching	Pain	Redness	Sensitivity to Light
	Visual Disturbance				
Respiratory	Apnea	Chest Tightness	Choking	Cough	Shortness of Breath
	Voice Change	Wheezing			
Cardiovascular	Chest Pain	Leg Swelling	Palpitations		
GI	Abdominal Bloating	Abdominal Pain	Rectal Bleeding	Blood in Stool	Bowel Incontinence
	Constipation	Diarrhea	Nausea	Rectal Pain	Vomiting
Endocrine	Cold Intolerance	Heat Intolerance	Excessive Thirst	Excessive Appetite	Urinary Frequency
Genital – Urinary	Bladder Incontinence		Breast Lump	Decreased Libido	Difficulty Urinating
	Pain w/intercourse	Painful Urination	Increased Urinary Frequency		Enuresis
	Flank Pain	Frequency	Genital Sores		Hematuria
	Menstrual Changes	Nocturia	Pelvic Pain		Sexual Difficulties
	Urgency	Decreased Urine	Vaginal Bleeding	Vaginal Discharge	Vaginal Pain
Musculoskeletal	Joint Pain	Back Pain	Gait Problems	Joint Swelling	Myalgia's
	Neck Pain	Neck Stiffness			
Skin	Color Change	Hair Change	Hair Loss	Nail Change	Pallor
	Rash	Skin Change			
Allergy	Environmental Allergies		Food	Immunocompromised	
Neurological	Dizziness	Facial Asymmetry	Headaches	Light Headedness	Numbness
	Seizures	Speech Difficulty	Syncope	Tremors	Weakness
Hematological	Lymph Node Swelling		Bruise/Bleed Easily		
Psychiatric	Agitation	Behavior Problem	Confusion	Decreased Concentration	
	Depressed Mood	Dysphoric Mood	Hallucinations	Hyperactive	Nervous/Anxious
	Self-Inquiry	Severe Stress	Sleep Disturbance	Suicidal Ideas	
Mood Screen	Little interest or pleasure in doing things:		Not at All	Several Days	Nearly Every Day
	Feeling down, depressed, or hopeless:		Not at All	Several Days	Nearly Every Day