

**@ Kirby**  
3701 Kirby, Suite 100  
Houston, TX 77098

**@ Baylor Clinic**  
6620 Main St. Suite 1250  
Houston, TX 77030

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Are you on  MyChart?

Please mark this monitor if you already submitted your health information online through MyChart. You will NOT need to fill out the sections of this form marked with a similar monitor. Please complete all unmarked sections.



**PATIENT INFORMATION**

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Title: \_\_\_\_\_ Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Last 4 of SSN \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Language preference: \_\_\_\_\_ By what name would you like to be called? \_\_\_\_\_

Blindness/Severe Vision Problems? Yes No Deafness/Severe Hearing Problems? Yes No

Because many medical conditions are influenced by race or ethnicity, the federal government has required that we ask for the following data on our patients. You have the right to decline to answer.

ETHNICITY:  Hispanic  Non-Hispanic

Check applicable RACE below:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Korean                | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Vietnamese            | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian           | <input type="checkbox"/> None of the Above      |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Native Hawaiian       |   |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Guamanian or Chamorro |   |

**EMPLOYER** \_\_\_\_\_ Occupation: \_\_\_\_\_ Bus. Phone: (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACTS**

Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Home/Cell: (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Home/Cell: (\_\_\_\_) \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Parent/Guardian Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Home/Cell: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

(If patient is over 18, parent / guardian must have the patient sign a medical records release to obtain clinical information)

**INSURANCE INFORMATION**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

**PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT**

**Please continue to the next page. Page 1 of 4**

**SOCIAL HISTORY**

Birthplace: \_\_\_\_\_ Education/Degree Level: \_\_\_\_\_

Relationship status:  Single  Married  Committed relationship  Separated  Divorced  Widowed

Who lives at home with you? \_\_\_\_\_

**MEDICAL HISTORY**

Check this monitor if this section was submitted online through MyChart



Please check conditions **YOU** have now, or have had in the past or list below.

- Alcohol/drug Abuse
- Anemia
- Anxiety
- Arthritis
- Asthma
- Bleeding Disorder
- Breast Lump
- Cancer: \_\_\_\_\_
- Cataracts
- Depression
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Kidney Disease
- Liver Disease
- Migraine Headaches
- Prostate Problem
- Rheumatic Fever
- Stroke
- Thyroid Problem
- Tuberculosis
- Sexually Transmitted Diseases

Other (please list): \_\_\_\_\_

**SURGERIES**

Check this monitor if this section was submitted online through MyChart



Please check or list the surgeries **YOU** have had.

- Appendectomy
- Gallbladder Removed
- Heart Bypass/Stent
- Tonsilectomy
- Hysterectomy
- Tubal Ligation
- Other: \_\_\_\_\_

**HOSPITALIZATIONS** List all of your hospital stays for illness or surgery beginning with the most recent.

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Physician</u>

**ACCIDENTS-TRAUMA-MENTAL HEALTH**

	Yes	No	N/A		Yes	No
Do you wear helmets with biking/skating?						
Do you have smoke detectors?				If yes, are they in working order?		
Do you have handguns?				If yes, are they secured?		
Do you wear seatbelts?				If yes, do you wear them 100% of the time?		
Do you drink and drive?						
Do you participate in extreme sports?				If yes, do you use protective gear?		
→ → → Do you feel safe at home?						
→ → → In the last 2 weeks, have you felt down, depressed or hopeless?						
→ → → In the last 2 weeks, have you felt little interest or pleasure in doing things?						

**ALLERGIES** If you are allergic to any of the following medications, please describe the reaction you had.

- None  Penicillin \_\_\_\_\_  Sulfa \_\_\_\_\_  Other \_\_\_\_\_

**MEDICATIONS, VITAMINS, SUPPLEMENTS** Check the following non-prescription medications that you use. Our staff will enter your prescription medications into our electronic medical record, so please have that information ready.

- Acetaminophen (Tylenol)
- Allergy Pills
- Antacids
- Aspirin
- Decongestants
- Ibuprofen (Advil, Motrin)
- Laxatives
- Naproxen (Aleve)
- Nasal Sprays
- Natural Hormones
- Supplements
- Vitamins (Please list)
- Herbs (Please list)

**PRESCRIPTION MEDS** (please list): \_\_\_\_\_

**MENSTRUAL HISTORY**

First date of last period \_\_\_\_\_ If menopausal, age at last period \_\_\_\_\_

Periods irregular?  Yes  No How many pregnancies \_\_\_\_\_ Number of children born alive? \_\_\_\_\_

Birth Control  Pills  Condoms  IUD  Surgery  Other: \_\_\_\_\_

**LIFESTYLE CHOICES**

Check this monitor if this section was submitted online through MyChart



**Smoking Status**

Type:  Never  Currently  Quit: YEAR \_\_\_\_\_  
 Cigarettes (Packs/day \_\_\_\_\_)  Cigars  Pipes  Second-hand Smoke  
 Never  Currently  Snuff  Chew  Quit: YEAR \_\_\_\_\_

**Smokeless Tobacco**

**Alcohol Use**

Type:  Liquor  Wine  Beer  
 0 drinks/week  1-6 /week  7-14 /week  Over 14/week

On any single occasion during the past **3 months**, have you had more than **5 drinks** containing alcohol?  Yes  No

**Weight**

Now \_\_\_\_\_ 1 year ago \_\_\_\_\_ Desired \_\_\_\_\_

**Caffeine**

Drinks per day \_\_\_\_\_ Types:  Cola  Coffee  Tea

**Special diet?**

Vegetarian  Vegan  Other: \_\_\_\_\_

**Exercise**

Type: \_\_\_\_\_ Frequency per week \_\_\_\_\_ Duration: \_\_\_\_\_

**FAMILY HISTORY**

Check here if you were ADOPTED



Does anyone in your **IMMEDIATE family** (parents, siblings & children only) have:

Disease	Yes	No	Relationship of Relative	Age Diagnosed
Breast Cancer				
Ovarian Cancer				
Prostate Cancer				
Colon Cancer				
Melanoma				
Osteoporosis				
Diabetes				
Heart attack/bypass/stent/stroke*				

\*Male <55 years old; female <65 years old



Does anyone in your **IMMEDIATE or EXTENDED family** have any of the following:

Disease	Relationship of Relative	Disease	Relationship of Relative
Anxiety		Sickle Cell Anemia	
Asthma		Suicide	
CVA/Stroke		Thyroid disease	
Depression		Tuberculosis	
Diabetes		Substance Abuse	
Heart attack		Cancer: _____	
High blood pressure		Cancer: _____	
High cholesterol		Other: _____	
Kidney disease		Other: _____	

Tell us about your **immediate family members**:

Family Member	If Living		If Deceased	
	Birth Year	Health Status	Age at Death	Cause
Father				
Mother				
1. Brother/Sister (circle one)				
2. Brother/Sister (circle one)				
3. Brother/Sister (circle one)				
Spouse				
1. Son/Daughter (circle one)				
2. Son/Daughter (circle one)				
3. Son/Daughter (circle one)				

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**PREVENTIVE SERVICES** List the **DATE** you last had these preventive medicine services or tests.

Last Physical: \_\_\_\_\_ Physician: \_\_\_\_\_

High cholesterol: \_\_\_\_\_

**Screening**

Mammogram \_\_\_\_\_  
 Pap smear \_\_\_\_\_  
 Colonoscopy \_\_\_\_\_  
 Prostate check \_\_\_\_\_  
 Bone Density \_\_\_\_\_

**Health Maintenance**

Dentist Visit \_\_\_\_\_  
 Eye exam (if needed) \_\_\_\_\_

**Immunizations**

Last Tetanus \_\_\_\_\_  
 Shingles shot \_\_\_\_\_  
 Pneumonia shot \_\_\_\_\_  
 HPV \_\_\_\_\_  
 Flu \_\_\_\_\_

Circle any of the following symptoms you've had in the last 2 weeks.

<p><b>General:</b>          loss of appetite          weight loss          chills          fevers          sweats          fatigue          sleep disorder</p> <p><b>Eyes:</b>          blurred vision          double vision          vision loss or blindness          discharge          redness          eye pain          yellow eyes</p> <p><b>Ear/Nose/Throat:</b>          ear drainage          earaches          hearing loss          ear ringing          nose bleeds          snoring          sore throat          hoarseness</p> <p><b>Endocrine:</b>          urinating a lot          drinking a lot          poor wound healing          temperature intolerance          hot flashes</p>	<p><b>Cardiovascular:</b>          chest pain or pressure          swelling in feet          calf pain with walking          irregular heart beats          palpitations          fainting          lightheadedness</p> <p><b>Respiratory:</b>          cough          sputum          short of breath          coughing blood          pleurisy          wheezing</p> <p><b>Gastrointestinal:</b>          abdominal pain          difficult or painful swallowing          indigestion          nausea          vomiting          diarrhea          constipation          change in bowel habits          black tarry stool          blood in stools          jaundice</p> <p><b>Blood/Lymph:</b>          bleeding          easy bruising          swollen lymph nodes</p>	<p><b>Genito-urinary:</b>          decreased stream          painful urination          frequency          blood in urine          getting up to urinate at night          urinary incontinence          abnormal menstrual periods          vaginal discharge          pelvic pain          genital lesions          penile discharge          erectile dysfunction</p> <p><b>Musculoskeletal:</b>          joint pains          joint swelling          stiff joints          neck pain          back pain          muscle cramps          muscle weakness</p> <p><b>Neurology:</b>          balance problems          difficulty walking          frequent falls          dizziness          headaches          memory problems          numbness          seizures          tremor          weakness</p>	<p><b>Breast:</b>          lump          tenderness          nipple discharge</p> <p><b>Skin:</b>          changed mole          hair changes          itchy skin          rash          skin color change</p> <p><b>Allergic:</b>          anaphylaxis          hay fever          hives</p> <p><b>Psychiatric:</b>          abusive relationship          anxiety          depression          mood swings          behavior problems          confusion          memory problems          excessive alcohol          consumption          illegal drug usage          hallucinations          paranoia          school difficulties          separation anxiety          sexual difficulty          sleep disturbance          suicidal thoughts</p>
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**Finished! Page 4 of 4**  
**Please give this form to a member of our staff.**  
**Thank you for choosing Baylor Family Medicine**