

Family Medical Center at Garland

A Baylor-HealthTexas Affiliate

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Family Medical Center at North Garland

A Baylor-HealthTexas Affiliate

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HEALTH HISTORY

NOTE: If you have previously filled out these forms with us, you need only list new information, or changes.

NAME _____ BIRTH DATE _____ SEX _____ DATE _____

MARRIED _____ SINGLE _____ DIVORCED _____ NO. OF PREVIOUS MARRIAGES _____

WHAT PROBLEM BROUGHT YOU TO THE DOCTOR? _____

WHEN DID IT BEGIN? _____

WHAT HELPS? _____

WHAT MAKES IT WORSE? _____

PAST HISTORY OF SAME PROBLEM? _____

SOUGHT HELP IN PAST? _____

WHAT OTHER PROBLEMS BOTHER YOU? (List)

HAVE YOU EVER HAD:

SERIOUS CHILDHOOD ILLNESS: (List) (eg. Chickenpox, rheumatic fever) _____

PAST MEDICAL HISTORY, HOSPITALIZATIONS, AND/OR PRIOR TRANSFUSIONS: (List)

TYPE _____ DATE _____

PREVIOUS SURGERY: (List)

TYPE _____	DOCTOR _____	DATE _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SERIOUS INJURIES, BROKEN BONES, CONCUSSION, ETC: (List) _____

PREVIOUS IMMUNIZATIONS AND DATES: TETANUS _____ PNEUMOVAX _____ FLU _____ OTHER _____

HISTORY OF SEXUALLY TRANSMITTED DISEASES: (Please List) _____

HISTORY OF ALLERGY TO DRUGS OR OTHER SUBSTANCES: (List) _____

HAVE YOU EVER HAD DIAGNOSTIC STUDIES:

	YEAR	RESULT
UPPER G.I. (STOMACH X-RAY) _____	_____	_____
IVP (KIDNEY) _____	_____	_____
GALL BLADDER _____	_____	_____
BARIUM ENEMA (COLON X-RAY) _____	_____	_____
ELECTROCARDIOGRAM _____	_____	_____
TREADMILL (STRESS) TEST _____	_____	_____
FLEX SIG/COLONOSCOPY _____	_____	_____

FAMILY HISTORY: PLEASE INDICATE IN THE SPACES BELOW ANY FAMILY MEMBERS WITH A HISTORY OF TUBERCULOSIS, DIABETES, HEART DISEASE, CANCER, EMPHYSEMA, KIDNEY DISEASE, ASTHMA, BLEEDING TENDENCIES, ANEMIA, EPILEPSY, GLAUCOMA, HIGH BLOOD PRESSURE, GOUT, ARTHRITIS, ULCER, STROKE, ANXIETY DISORDER, NERVOUS BREAKDOWN.

	IF LIVING		IF NOT LIVING	
	AGE	HISTORY OF ILLNESSES	AGE AT DEATH	CAUSE
FATHER _____	_____	_____	_____	_____
PATERNAL GRANDFATHER _____	_____	_____	_____	_____
PATERNAL GRANDMOTHER _____	_____	_____	_____	_____
MOTHER _____	_____	_____	_____	_____
MATERNAL GRANDFATHER _____	_____	_____	_____	_____
MATERNAL GRANDMOTHER _____	_____	_____	_____	_____
BROTHERS _____	_____	_____	_____	_____
SISTERS _____	_____	_____	_____	_____
SONS _____	_____	_____	_____	_____
DAUGHTERS _____	_____	_____	_____	_____

ANY OTHER FAMILY MEMBERS WITH ILLNESSES NOTED ABOVE? _____

PERSONAL HISTORY:

OCCUPATION _____

RECENT CHANGE _____

RELIGIOUS PREFERENCE _____

AMOUNT OF SMOKING DAILY _____ NUMBER OF YEARS SMOKED _____

SMOKELESS TOBACCO? _____ IF SO, TYPE AND AMOUNT _____ IF QUIT, WHEN _____

DO YOU DRINK ALCOHOL? YES _____ NO _____ IF YES, AMOUNT OF ALCOHOL ON AN AVERAGE:

DAY _____ WEEK _____ MONTH _____

AMOUNT OF CAFFEINE DAILY _____

HIV RISK FACTORS (CIRCLE ALL THAT APPLY) 1.) UNPROTECTED SEX 2.) HISTORY OF IV DRUG USE
3.) BLOOD TRANSFUSION BEFORE 1980 4.) KNOWN EXPOSURE TO HIV + PERSON 5.) HEALTHCARE WORKER
6.) SEX WITH A PROSTITUTE OR PERSON WHO HAS USED IV DRUGS

MEDICINES USED:	DRUG NAME	STRENGTH	HOW OFTEN TAKEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU EXERCISE REGULARLY? _____ HOW OFTEN DO YOU EXERCISE? _____

WHAT TYPE OF EXERCISE? _____

EDUCATIONAL LEVEL, DEGREES, TECHNICAL, BUSINESS TRAINING _____

DO YOU HAVE NOW, OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? PLEASE CHECK IF PERTINENT.

HEADACHES _____	LOSS OF SENSE OF SMELL _____
HEAD INJURY _____	SORES IN MOUTH _____
EYE PAIN _____	PAINFUL OR BLEEDING GUMS _____
SWOLLEN OR RED EYES _____	TOOTHACHE _____
GLASSES _____	FALSE TEETH _____
EARACHE OR DRAINAGE _____	FREQUENT SORE THROATS _____
RINGING IN EARS _____	DIFFICULTY SWALLOWING _____
HEARING LOSS _____	HOARSENESS _____
DIZZINESS _____	SPEECH DIFFICULTY _____
DRAINAGE FROM NOSE _____	STIFF, PAINFUL NECK _____
FREQUENT COLDS, HAYFEVER _____	LUMPS OR SWELLING NECK _____
SINUS PAIN (FOREHEAD, CHEEKS) _____	FREQUENT NOSEBLEEDS _____
BLURRED OR DOUBLE VISION _____	THYROID TROUBLE _____
SEE HALOS AROUND LIGHTS _____	

SKIN TROUBLE SUCH AS (CIRCLE): HIVES, MOLES, SCALING, FREQUENT INFECTIONS, SCALP PROBLEMS, RASH,
OTHER: _____

COUGH UP SPUTUM _____	PNEUMONIA _____
SWEATING AT NIGHT _____	COUGHING UP BLOOD _____
WHEEZING OR ASTHMA _____	PAIN IN CHEST ON COUGHING OR BREATHING _____
EMPHYSEMA _____	FREQUENT COUGH _____
RAPID HEARTBEAT _____	HIGH BLOOD PRESSURE _____
IRREGULAR HEARTBEAT (PALPITATIONS) _____	CHEST DISCOMFORT _____
SHORTNESS OF BREATH: _____	HEART MURMUR _____
WITHOUT EXERCISE _____	RHEUMATIC FEVER _____
WITH EXERCISE _____	SWELLING HANDS, FEET, ABDOMEN _____
ON LYING FLAT IN BED _____	SKIN TURNS BLUE _____
AWAKENS ME _____	FAINING OR BLACKOUTS _____

HEART DISEASE _____	PAIN IN CALVES OR THIGHS WHEN WALKING _____
DIFFICULT SWALLOWING _____	VOMITING BLOOD _____
INCREASED APPETITE _____	DIARRHEA _____
LOSS OF APPETITE _____	PAINFUL BOWEL MOVEMENTS _____
EXCESS GAS, BLOATING SENSATION _____	HEARTBURN _____
BELCHING _____	BLACK BOWEL MOVEMENTS _____
NAUSEA OR VOMITING _____	
ABDOMINAL PAIN _____	SEXUAL PROBLEMS, CHANGE IN INTEREST _____
ANY QUESTIONS REGARDING SEX _____	
	BLOOD IN URINE _____
ELEVATED BLOOD SUGAR (DIABETES) _____	CLOUDY URINE _____
JAUNDICE (YELLOW SKIN) _____	ABNORMAL VOLUME OF URINE _____
	HISTORY OF VENEREAL DISEASE _____
PASSING BLOOD RECTALLY _____	PASSING STONES IN URINE _____
CONSTIPATION _____	KIDNEY DISEASE _____
CONVULSION, EPILEPSY _____	FOR MEN:
MENTAL CONFUSION _____	PROSTATE TROUBLE _____
DIFFICULTY WALKING _____	DISCHARGE FROM PENIS _____
	PROBLEMS WITH ERECTIONS _____
DIZZINESS _____	ANY SWELLING OR BUMPS IN TESTICLES _____
STROKE _____	PAIN IN TESTICLES _____
NEURITIS, NEURALGIAS _____	DO YOU DO SELF TESTICULAR EXAMS _____
TINGLING _____	
	FOR WOMEN:
NUMBNESS _____	AGE WHEN MENSTRUAL PERIODS BEGAN _____
PARALYSIS, WEAKNESS OF EXTREMITIES _____	DURATION OF PERIODS _____ DAYS
PERSONALITY CHANGE _____	INTERVAL BETWEEN PERIODS _____ DAYS
DIFFICULTY SLEEPING _____	PERIODS: REGULAR _____ IRREGULAR _____
CRYING SPELLS, SADNESS _____	BLEEDING BETWEEN PERIODS _____
TREMOR OR SHAKING _____	DATE OF LAST MENSTRUAL PERIOD _____
LOSS OF INTEREST IN WORK OR HOBBIES _____	DATE OF PREVIOUS MENSTRUAL PERIOD _____
INCREASED NERVOUSNESS _____	DO YOU TAKE BIRTH CONTROL PILLS _____
HEAR SOUNDS OR SEE VISIONS _____	AGE WHEN PERIODS CEASED _____
NERVOUS BREAKDOWN _____	VAGINAL BLEEDING SINCE MENOPAUSE _____
SUICIDAL THOUGHTS _____	LUMPS IN BREAST _____
	BLOATED AND IRRITABLE BEFORE PERIODS _____
BACKACHE _____	VAGINAL DISCHARGE _____
SORE JOINTS OR MUSCULAR PAIN _____	VAGINAL ITCHING _____
SWELLING JOINTS, ARTHRITIS _____	NO. OR PREGNANCIES _____
BONE DISEASE _____	COMPLICATIONS _____
BURSITIS _____	NO. OF MISCARRIAGES _____
GOUT _____	PAINFUL PERIODS _____
RHEUMATISM _____	PAIN WITH INTERCOURSE _____
	SCANT PERIODS _____
BURNING ON URINATION _____	DATE OF LAST CANCER SMEAR OF CERVIX _____
KIDNEY, BLADDER INFECTION _____	NORMAL _____ ABNORMAL _____
LOSE URINE ACCIDENTALLY _____	HEAVY PERIODS _____
CHANGE IN URINARY FREQUENCY (MORE OR LESS) _____	PRESENT CONTRACEPTIVE METHOD _____
DIFFICULTY STARTING STREAM _____	(OTHER THAN PILL) _____
URINATION AT NIGHT _____	HAVE YOU HAD AN ABORTION? IF YES, NUMBER _____
	DO YOU DO SELF BREAST EXAMS _____
WEIGHT CHANGE OF GREATER THAN 5 POUNDS _____	PERSISTENT FEVER (>2 WEEKS) _____
(SPECIFY AMOUNT) _____	
UNUSUAL THIRST _____	URINARY FREQUENCY _____
HEAT OR COLD INTOLERANCE _____	NIGHT SWEATS _____