Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Name: _____

DOB: _____

Date: _____

MRN#: _____

Thank you for choosing Baylor Scott & White HouseCalls. We appreciate your assistance by completing this form, as it will help us better care for you.

How did you hear about BSW HouseCalls? _____

Reason for visit: _____

What questions or concerns would you like to discuss?_____

_____

ALLERGIES

List any significant reactions to food/meds ☐ **No known allergies**

Allergy	Reaction		Allergy	Reaction

MEDICATIONS

List any medications you take, prescription and nonprescription and their dosage: ☐ **No medications**

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

Local Pharmacy: _____ **Phone Number:** _____

Address: _____**City:**_____

Mail order Pharmacy:_____

Your Care Team: Please provide the names of other providers/specialties that you currently receive care from.

Provider	Specialty		Provider	Specialty

PAST MEDICAL HISTORY

Please check all that apply. ☐ No medical problems

	Abdominal Aneurysm		**GERD/Acid Reflux**		**Kidney stones**
	Anxiety		**Gout**		**Osteoporosis**
	Arthritis		**Hearing loss**		**Parkinson's Disease**
	Asthma		**Heart Valve Disease**		**Peripheral neuropathy**
	Atrial fibrillation		**Heart attack**		**Peripheral vascular disease**
	Breast cancer		**Hepatitis A/B/C**		**Pressure Injury/wound**
	Colon Cancer		**High cholesterol**		**Recurrent urine infections**
	Colon Polyps		**Hypertension**		**Recurrent falls**
	COPD/Emphysema		**Hyperthyroidism**		**Seizures**
	Crohn's disease		**Hypothyroidism**		**Stroke**
	Dementia		**Irritable Bowel Syndrome**		**Ulcerative Colitis**
	Depression		**Kidney disease**		**Urinary Incontinence**
	Diabetes		**Migraines**		

Additional history:_____

SURGICAL HISTORY

Please check all that apply: ☐No surgeries

	Appendectomy		**Colon surgery**		**Kidney stone/lithotripsy**
	Back Surgery		**Cosmetic surgery**		**Mastectomy**
	Breast surgery		**Eye surgery**		**Pacemaker insertion**
	CABG/Heart bypass		**Femoral popliteal bypass**		**Small intestine surgery**
	Brain surgery		**Fracture surgery**		**Spinal fusion**
	Heart catheterization		**Heart valve surgery**		**Stomach surgery**
	Carotid endarterectomy		**Hernia repair**		**Ventral hernia**
	Carpal tunnel release		**Hip replacement**		**VP (brain) shunt**
	Cataract removal		**Joint replacement**		**Whipple procedure**
	Brain aneurysm		**Knee replacement**		
	Gallbladder surgery				

FAMILY HISTORY

Please check all that apply: GM=grandmother GF=grandfather

	Mother	Father	Sister	Brother	Daughter	Son	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Other
No known problems											
Alcohol abuse											
Alzheimer's disease											
Anxiety disorder											
Asthma											
Cancer											
Colon cancer											
COPD/Emphysema											
Depression											
Diabetes											
Hearing loss											
Heart attack											
Heart disease											
High cholesterol											
Hypertension											
Illicit drug use											
Intellectual disability											
Kidney disease											
Learning disability											
Lung cancer											
Melanoma											
Mental illness											
Osteoporosis											
Parkinson's disease											
Stroke											
Thyroid disease											
Vision Loss											

SOCIAL HISTORY

Alcohol use: ❑ Yes ❑ Not Currently ❑ Never

How often do you have a drink containing alcohol?
❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 2-3 times a week ❑ 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking? _____

How often do you have 6 or more drinks on one occasion?
❑ Never ❑ Less than monthly ❑ Weekly ❑ Daily or almost daily

Drinks per week: _____Glasses of wine _____Cans of beer _____Shots of liquor
_____Standard drinks or equivalent

Sexually Active: _____ ❑ Yes ❑ Not currently ❑Never

Partners: _____ ❑ Female ❑ Male

Drug Use: ❑ Yes ❑ Not currently ❑ Never Type of Drugs: _____

Tobacco Use: ❑ Yes ❑ Not currently ❑ Never

If so what type: ❑ Cigarettes ❑Pipe ❑Cigars ❑Electronic cigarettes ❑Snuff ❑Chew

Year Started: _____ Packs/day: _____ Quit Date:_____

Occupation: ❑Retired _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Number of children: _____

Education completed: ____ grade ❑ high school ❑ college

Who lives with you? _____

Who is in your support system? (circle those that apply)

Case manager	Children	Family	Faith based	Friends	Home care staff
Legal guardian	Neighbors	Parents	Partner	Shelter	Significant other
Social worker	Spouse	Therapist	Twelve step group	NONE	

Who would help if you became ill or injured? (circle those that apply)

Caregiver	Children	Family	Father	Friend	Grandparent
Legal guardian	Mother	Parent	Spouse/Partner	Significant other	

Are you lonely most days? ❑ Yes ❑ No

Does anyone, including family, bully you, insult you, talk down to you, scream or curse at you, threaten you with harm, or physically hurt you? ❑ Yes ❑ No

What keeps you from being healthier?

Transportation	Food	Unable to exercise	Not motivated	Inadequate insurance	Not enough time
Medication cost	Child care	Utilities	NO BARRIERS		

Do you wear seat belts? ❑ Yes ❑ No

Do you ride a motorcycle or bicycle? ❑ Yes ❑ No

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all	Not very hard	Somewhat hard	Hard	Very hard

Have you been worried that your food would run out before you got money to buy more?

Never true	Sometimes true	Often true

Has the food you bought just didn't last and you didn't' have money to get more?

Never true	Sometimes true	Often true

Has lack of transportation kept you from medical appointments or from getting medication? ❑ Yes ❑ No

Has lack of transportation kept you from getting things needed for daily living? ❑ Yes ❑ No

How many times have you fallen in the past year?_____; were you injured? ❑ Yes ❑ No

Do you feel unsteady or wobbly when standing or walking? ❑ Yes ❑ No

Do you need assistance to walk or a wheelchair? ❑ Yes ❑ No

Do you worry about falling? ❑ Yes ❑ No

If recommended to use a cane or walker, do you use it consistently? ❑ Yes ❑ No

If recommended Do you need help with any of the following activities? (Circle the amount of help needed)

Bathing	Independent	Dependent
Dressing	Independent	Dependent
Toileting	Independent	Dependent
Transferring	Independent	Dependent
Urinary Continence	Independent	Dependent
Eating	Independent	Dependent
Use the telephone	Independent	Dependent
Shopping and Errands	Independent	Dependent
Food Preparation	Independent	Dependent
Housekeeping	Independent	Dependent
Mode of transportation	Independent	Dependent
Medication Management	Independent	Dependent
Ability to handle finances	Independent	Dependent

OB/GYN HISTORY

Age of Last Menstrual period: _____ ❑Postmenopausal

Postmenopausal vaginal bleeding: ❑Yes ❑No

# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____

IMMUNIZATIONS Please enter the dates of your most recent vaccination

Tetanus/TdaP/Td: _____ Human Papilloma Vaccination (HPV)/Gardasil:_____

Prevnar:_____ Pneumovax:_____

Zostavax /Shingrix Vaccination: _____ Influenza Vaccination: _____

PREVENTIVE CARE Please enter the dates of your most recent tests.

	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
Osteoporosis Test/DEXA		
For Women Only		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		
Prostate Exam		
PSA		

ADVANCE 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.

Baylor Scott & White HouseCalls

Pt Name: _____ DOB: _____Date: _____

REVIEW OF SYSTEMS QUESTIONNAIRE

In order to accurately assess your concerns, please CIRCLE any of the symptoms below that you have experienced in the past 2 weeks.

CONSTITUTIONAL	Activity Change	Appetite Change	Chills	Chronic Pain	Daytime Sleepiness
	Excessive Sweating	Fatigue	Fever	General Weakness	Unexpected Wt Change
HEAD/EARS/NOSE/ THROAT	Congestion	Dental Problem	Drooling	Ear Pain	Facial Swelling
	Hearing Loss	Mouth Sores	Nosebleeds	Post Nasal Drip	Reflux
	Runny Nose	Sinus Pain	Sinus Pressure	Sneezing	Snoring
	Ringing in ears	Vertigo	Sore throat	Trouble	Voice Change
EYES	Discharge	Itching	Pain	Redness	Sensitivity to Light
	Visual Disturbance				
RESPIRATORY	Gasping for air	Chest Tightness	Choking	Cough	Shortness of Breath
	Voice Change	Wheezing	Sleep Apnea		
CARDIOVASCULAR	Chest Pain	Leg Swelling	Palpitations	Pain in legs with walking	
GI	Abdominal Bloating	Abdominal Pain	Anal Bleeding/Pain	Blood in Stool	Bowel Incontinence
	Constipation	Diarrhea	Nausea	Heartburn	Vomiting
ENDOCRINE	Cold Intolerance	Heat Intolerance	Excessive Thirst	Excessive Appetite	Urinary Frequency
GENITAL/URINARY	Bladder	Breast Lump	Decreased Libido	Difficulty	Pain w/Intercourse
	Painful Urination	Increased Urinary Frequency		Night Incontinence	Flank Pain
	Frequency	Genital Sore	Blood in Urine	Menstrual Change	Urination at
	Pelvic Pain	Sexual Difficulties	Urgency	Urine Decreased	Vaginal Bleeding
	Vaginal Discharge	Vaginal Pain			
MUSCULOSKELETAL	Joint Pain	Back Pain	Trouble Walking	Joint Swelling	Muscle Aches
	Neck Pain	Neck Stiffness			
SKIN	Color Change	Hair Change	Hair Loss	Nail Change	Paleness
	Rash	Skin Change	Poor Wound Healing	Skin Lesion	
ALLERGY	Environmental Allergies		Food Allergies	Immunocompromised	
NEUROLOGICAL	Dizziness	Facial Asymmetry	Headaches	Light-headedness	Numbness
	Seizures	Speech Difficulty	Passing out	Tremors	Arm or Leg
HEMATOLOGIC	Lymph Node	Bruise/Bleed Easily			
PSYCHIATRIC	Agitation	Behavior Problem	Confusion	Decreased Concentration	
	Depressed Mood	Sad	Hallucinations	Hyperactive	Nervous/Anxious
	Self-Injury	Severe Stress	Sleep Disturbance	Suicidal Ideas	