

Colleyville Family Medicine

A Baylor-HealthTexas Affiliate

Family Medicine
D. Michael Bell, D.O.
Ty Bush, D.O.
Jane F. Ensey, D.O.
Marilyn K. Justice, M.D.
Margaret H. Walter, D.O.

Internal Medicine
Lorrie B. Hayes, M.D.

Pediatrics
Elizabeth A. Henderson, M.D.

5232 Colleyville Boulevard, Suite 100
Colleyville, Texas 76034

(817) 912-9920
(817) 498-0635 Fax
colleyvillefamilymedicine.com

Date: ____/____/____

Dear: _____,

Your Physical Exam is scheduled on:

_____ / _____ / _____ at _____ a.m. / p.m.

- **Please complete the enclosed forms and bring them with you at the time of your appointment.**
- Wellness exams frequently require laboratory evaluation and testing with a thorough physical exam. Please wear appropriate clothing to allow easy changing.
- If your scheduled appointment is in the morning, laboratory work may be needed, so please do **not** eat or drink anything 12 hours prior to your appointment time. **You may have water, all the water you want during your fast, and one cup of black coffee, or one cup of black non-herbal tea.**
- If your wellness exam is scheduled in the afternoon, it will require a long period of fasting and your options are as follows:
 1. You may elect not to eat or drink for 12 hours prior to your appointment time **(you may have all the water that you want during your fast, and one cup of black coffee, or one cup of black non-herbal tea)**. Labs can then be drawn at the time of your afternoon appointment.
 2. We will perform your exam and order the laboratory tests to be drawn at a later date.
- If you are unable to keep this appointment please notify us as soon as possible so we can fill your appointment slot with another patient. If you fail to cancel the appointment within **24 hour notice**, you will be billed \$100.00 cancellation fee.

If you have any questions or concerns, please call our office at (817) 912-9920.

Sincerely,

Physicians & Staff at Colleyville Family Medicine

Colleyville Family Medicine

Medical History for the Initial Exam

Note to the patient: This is a very detailed and thorough medical history form. The more knowledge about your medical history is gained, the better I will be able to assist in helping you manage all your health care needs. Some of the questions are very personal in nature and may be difficult or embarrassing for you to answer. I can assure you that they are very important or they would not be asked. Your medical record is being kept in complete confidence. We only release your medical information upon your signed consent. *Therefore, please take your time and complete this form as accurately as possible.*

Name: _____ **Age:** _____ **Date Completed:** ____/____/____
 Last Name First Name MI

Race: Caucasian Black Hispanic Oriental American Indian Other _____

Date of Birth: ____/____/____ **Place of Birth:** _____

Please rate what you consider to be your overall general health: (Poor) 1 2 3 4 5 (Good)

Allergies: (Please list any allergies you have to medications, foods or environmental substances)

Allergy	What happens when you are exposed to this?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications: (include those prescribed and those purchased over the counter. Include vitamins, herbs, laxatives and cold medicines)

Name of Medication	Strength	How often Taken?	How long have you been on this medication (years)?	Prescribed by (Dr's Name)

Travel History: (Indicate if you have traveled out of the country in the last 24 months)

Place of visit outside of the Unites States	Visited	Lived	How Long in months / years
_____	<input type="radio"/>	<input type="radio"/>	_____
_____	<input type="radio"/>	<input type="radio"/>	_____
_____	<input type="radio"/>	<input type="radio"/>	_____
_____	<input type="radio"/>	<input type="radio"/>	_____

Past Medical History: (Place a check if you have ever had any of the following diseases, and the age if remembered)

- | | | | | |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Polio | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> UTI | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Anemia (low red blood count) | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Migraine Headache | |
| <input type="checkbox"/> Phlebitis (vein inflammation) | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Protein in Urine | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Hay Fever or Sinus Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Stomach Ulcer | |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Cirrhosis | | | |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Gallbladder Infection | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth Defect |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Major Trauma | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Learning Disability | |
| <input type="checkbox"/> Depression or Mental Illness | <input type="checkbox"/> Radiation Exposure (other than X-Rays) | | | |

Surgical History:

Surgical Procedure	Year	Hospital	Doctor

Injuries:

Age and/or year	Description	Treatment	Doctor

Hospitalizations:

Age and/or year	Description	Treatment	Doctor

Nutrition:

How many meals do you eat per day? _____ Are you happy with your current weight? Yes No
Do you ever binge? Yes No Do you ever vomit or use laxatives for weight control? Yes No
Do you take vitamins or eat "health foods" for weight management? Yes No

*** If yes, to any of the above questions, please list more detail: _____

Prevention:

Do you exercise on a regular basis? Yes No How many days per week? _____ How long do you exercise? _____

***If yes, what type of exercise? Weights Running Aerobics Other: _____

How often do you see a doctor? Regular visits/prevention Only when ill

When was the last time you saw the eye doctor? _____ The dentist? _____

Have you ever had your hearing checked? Yes No If yes, when: ____/____/____

Immunizations: (Immunization history is important and if you have a record, please provide a copy to your provider)

Date of last: Flu Shot _____ Tetanus Shot _____ Pneumovax _____
TB Skin Test _____ Results: Negative Positive Ever been treated for TB? Yes No

Date of last: Complete history & Physical Exam _____ Blood Test: _____
EKG _____ Have you ever had an Abnormal EKG? Yes No
Chest X-Ray _____ Have you ever had an Abnormal Chest X-Ray? Yes No

Habits:

How often do you drink alcoholic beverages? Daily Weekly Monthly Less than once a month Never

What do you drink? Wine Beer Mixed Drinks How much do you consume at a sitting? _____

I stopped drinking alcohol since: _____

Do you smoke cigarettes or cigars? Yes No If yes, how many packs per day? _____ How long? _____ years

Do you or have you used any other tobacco products? Yes No Type: Dip Chew Pipe Other

Have you ever used street drugs (marijuana, cocaine, Quaalude, methamphetamine, ecstasy)? Yes No

If yes, what type(s): _____ Ever used needles? Yes No

Do you still use street drugs? Yes No If no, when did you stop? _____ If yes, when last used? _____

Sexual History:

Do you consider yourself: heterosexual homosexual bisexual

Have you had more than one sexual partner in the past year? Yes No

Have you ever been a victim of sexual abuse? Yes No If yes, have you received counseling? Yes No

Do you ever feel like you may have been drugged before having sex? Yes No

Risk factors for HIV (Human Immune Deficiency Virus)

Do you have any tattoos? Yes No Have you had any homosexual or bisexual relations? Yes No

Have you had sex with a known IV drug user? Yes No Prostitute? Yes No

Promiscuous partner (a partner who is homosexual or bisexual)? Yes No

Have you ever had a blood transfusion? Yes No If yes, when? _____

Women Only: Gynecologic History (Men Continue with System Review on Next Page)

Age at first period? _____ Age at first intercourse? _____ Age you stopped having periods? _____ Not stopped

Do you use birth control? Yes No If yes, what type: Pill Patch Condom Depo Provera Injection IUD Other

Menstrual cycle: occurs every _____ days Duration (time of period) _____ days The flow is: Heavy Moderate Light

Do you have cramps requiring medication during period? Yes No List any premenstrual symptoms you have: _____

Date of last mammogram? _____ Have you ever had an abnormal mammogram? Yes No

If yes, when? _____ What was the treatment? _____

Date of last pap smear? _____ Have you ever had an abnormal pap smear? Yes No

If yes, when? _____ What was the treatment? _____

Do you do self breast exams? Yes No If no, has anyone ever taught you how? Yes No

Women Only: Obstetrics History

Age at first pregnancy: _____ How many total times have you been pregnant? _____ How many deliveries? _____

Number of full term infants (38-42 weeks): _____ Number of premature infants (37 weeks): _____ Number of elective abortions: _____

Number of miscarriages: _____ Number of vaginal deliveries: _____ Number of cesarean sections: _____ Number of living children: _____

Did you have any complications before, during or after any of your deliveries, involving you or the infant? Yes No

If yes, please explain: _____

Will you describe the cause of death for any of your children? _____

System Review: (place a check by any of the following that you are currently experiencing and not previously evaluated by a doctor)

General:

- Fatigue
- Swollen lymph glands
- Difficulty sleeping
- Poor sexual drive (desire)
- Mouth ulcers
- Sore throat
- Dental problems
- Bleeding gums
- Hoarseness
- Teeth grinding
- Dentures
- None of the above*

Skin:

- Sores
- Bruises
- Rash
- Dryness
- Hair loss
- Nail changes
- Change in wart or moles
- None of the above*

Neck:

- Pain in motion
- Masses
- Stiffness
- Swelling
- None of the above*

Head and Eyes:

- Headaches
- Dry eyes
- Eye infection
- Watery eyes
- Eye pain
- Blurred vision
- Double vision
- Sensitivity to light
- Seeing "spots"
- Farsightedness
- Nearsightedness
- Wear glasses
- Wear contacts
- None of the above*

Ear/Nose/Throat:

- Difficulty hearing
- Ringing in the ears
- Ear infection
- Ruptured ear drum
- Dizziness
- Ear pain
- Hearing aid
- Nose bleeds
- Nasal polyps
- Nasal stuffiness
- Sinusitis
- Decrease in smell
- Runny nose
- Dry mouth
- Cold sores or Fever blisters
- None of the above*

Cardiopulmonary:

- Snoring
- Cough
- Sputum production
- Coughing up blood
- Shortness of breath (at rest)
- Shortness of breath (with activity)
- Wheezing
- Pain with breathing
- Fever
- Shaking chills
- Night sweats
- Requiring more than one pillow to aid breathing
- Rapid heartbeat
- Heart skips a beat
- Palpitations
- Chest pain
- varicose veins
- Pain in arm, neck or jaw
- Poor circulation
- Swelling of ankles or feet
- Leg cramps
- Fainting spells
- None of the above*

Gastrointestinal:

- Difficulty swallowing
- Pain with swallowing
- Frequent belching (burping)
- Heart burn
- Frequent use of antacids
- Nausea
- Vomiting
- Vomiting blood
- Diarrhea
- Constipation
- Black stools
- Mucous in stools
- Blood in stools or on toilet paper
- Loss of control of bowel movement
- Hemorrhoids
- Jaundice (yellow skin)
- Change in weight
- Change in appetite
- Food tolerance (upset stomach)
- Excessive gas
- Hiccups (recurrent)
- Feeling of fullness after small food intake
- Pain with passage of bowel movement
- Change in color or appearance of bowel movement
- Abdominal pain or cramping
- None of the above*

Genitourinary:

- Need to urinate more frequently than normal
- Burning with urination
- Urgent need to urinate
- Blood in urine
- Leakage of urine (unable to hold it)
- Get up at night to urinate
- Difficulty starting/stopping urinary stream
- None of the above*

Men Only:

- Ulcers or lesions
- Discharge from penis
- Inability to gain or maintain erection
- Masses or swelling of testicles
- Pain in testicles
- Pain in groin with lifting or straining
- Dribbling after urination
- None of the above*

Women Only:

- Vaginal discharge
- Vaginal dryness
- Vaginal itching
- Pain with sex
- Ulcers or lesions on genital area
- Pelvic pain
- Menstrual problems
- Breast lump
- Breast discharge
- None of the above*

Neuromuscular &

Musculoskeletal:

- Right handed
- Left handed
- Involuntary tremor (hands shake)
- Loss of sensation in hands or feet
- Tingling in hands or feet
- Inability to move arms or legs
- Convulsions
- Swelling of joints
- Pain in joints
- Deformed joints
- Stiff joints
- Pain in muscles
- Low back pain
- Difficulty walking
- Difficulty balancing
- Difficulty standing
- Difficulty lifting
- Difficulty stooping, bending, or squatting
- Frequent falls
- Heel pain
- Weakness
- Increased sensation
- Poor condition
- None of the above*

Neuropsychological:

- Personality change
- Difficulty speaking
- Confusion
- Memory loss
- Change in speech
- Change in behavior
- Suicidal thoughts
- Feelings of sadness/depression
- Anxiety (nervousness)
- None of the above*

Hematological:

- Easy bleeding
- Easy bruising
- Paleness
- None of the above*

Endocrine:

- Always thirsty
- Always hungry
- Intolerant to cold or heat
- Change in hair texture
- Increased body hair (Women)
- Inability to gain or lose weight
- None of the above*

Anything else you wish the doctor to know or have concerns about?

Signature of person completing this form

(For Physicians Only)

O I have read and reviewed this completed Medical History and ROS Form

Date: ____/____/____

Initials or Signature of Physician