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 Subsequent Exam

Name: ______________________________ **Age:**________ **Date Completed:** ____/____/____
Last Name First Name MI

Please note: *Please take your time and answer each question carefully and as complete as possible.*

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)

Have you had any surgeries or hospitalizations since last visit? O Yes O No
If yes, please list:

Type of Care/Surgery	Date of Care	Place of Care

Has your occupation changed since your last physical? O Yes O No
If yes, list new occupation:
____

Has your marital status changed since the last physical? O Yes O No
If yes, please indicate: O Divorce O Marriage O Widow O Separated

Have any new diseases been diagnosed in your family since the last physical? O Yes O No
(parents, siblings, grandparents) If yes, please list:

Family Member	Disease

Are you exercising regularly? O Yes O No
If yes, list activity: ______________________________

Have you quit smoking since your last physical? O Yes O No

Have you started smoking since your last physical? O Yes O No If yes, how many packs per day? ________

How many ounces of alcohol do you drink per week? ________________ **O I don't drink at all**

Do you use any street drugs? O Yes O No

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
	O	O	
	O	O	

Sexual History:

Do you consider yourself: O Heterosexual O Homosexual O Bisexual

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

Do you use birth control? O Yes O No

If yes, what type: O Pill O Patch O Condom O Depo Provera Injection O IUD O Other: ___________

Risk factors for HIV (Human Immune Deficiency Virus)

Do you have any tattoos? O Yes O No

Have you had any homosexual or bisexual relations? O Yes O No

Have you had sex with a know IV drug user? O Yes O No **Prostitute?** O Yes O No

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

Last exam by eye doctor? _________/_________ (month/year)

Last exam by dentist? _________/_________ (month/year) **Do you maintain regular visits?** O Yes O No

For Women: If Gynecology care received outside this office, please give date of:

Last PAP: _________/_________ (month/year) **Last Mammogram:** _________/_________ (month/year)

Performed by doctor: ____

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*

Cardiopulmonary:
- _____ Snoring
- _____ Cough
- _____ Sputum production
- _____ Coughing up blood
- _____ Shortness of breath (at rest)
- _____ Shortness of breath (with activity)
- _____ Wheezing

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*

Gastrointestinal:
- _____ Difficulty swallowing
- _____ Pain with swallowing
- _____ Frequent belching (burping)
- _____ Heart burn
- _____ Frequent us of antacids
- _____ Nausea
- _____ Vomiting

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*

Hematological:
- _____ Easy bleeding
- _____ Easy bruising
- _____ Paleness
- _____ *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

_____ 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*

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*

_____ 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*

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*

_____ 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*

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: _____/_____/_____ _______________________