Baylor Scott & White
CENTER FOR ADVANCED SURGERY
DALLAS
A member of HealthTexas Provider Network

HEALTH HISTORY QUESTIONNAIRE

Date _____

Patient Name _____ Date of Birth _____ Age _____

Daytime phone (____) _____ Other phone (____) _____

Email _____

How did you hear about us? ☐ My doctor ☐ Yellow pages ☐ News ad ☐ Radio/TV ☐ Friend/family

☐Web site ☐ Other _____

Reason for today's visit _____

Have you had the following tests:

Screening colonoscopy ☐ Yes If so, when? _____ ☐ No

Sleep study ☐ Yes If so, when? _____ ☐ No

Physicians

Referring Physician _____ Phone (____) _____

Primary Care Physician _____ Phone (____) _____

Surgeon _____ Phone (____) _____

Oncologist _____ Phone (____) _____

GI Physician _____ Phone (____) _____

Other MD _____ Phone (____) _____

Allergies	Yes	No	**Initials _____**
Contrast dye / Shellfish / Iodine	☐	☐	
Adhesives	☐	☐	
Dermabond	☐	☐	
Latex	☐	☐	

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Do you have any allergies to medications? ☐ Yes ☐ No
If **Yes**, please list the drugs and type of reaction:

_____

_____

Medications *- Please list your current medications and doses below*
Please include over-the-counter medications & supplements, i.e. vitamins, herbals, aspirin, etc.)

Name	**Strength**	**Frequency**

I DO NOT TAKE ANY MEDICATIONS – ☐ PLEASE √ BOX

Preferred Pharmacy _____

Medical History *– list any past/current problems and/or illnesses*
Examples: Diabetes, High Cholesterol, Hyperthyroidism or Heart Disease

_____

_____

_____

_____

Surgical History **– I HAVEN'T HAD ANY SURGICAL PROCEDURES ☐ PLEASE √ BOX**
Examples: Appendectomy, Colon Resection, Fundoplication, TIF, Bariatric

Surgery	**Where**	**Date**	**Any complications?**

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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Procedures

Please indicate if you have had any of the following procedures.

	Yes	No	Where	Date
CT Scan – Chest/Abdomen/Pelvis	☐	☐	_____	_____
Ultrasound – Abdomen	☐	☐	_____	_____
PET scan	☐	☐	_____	_____
pH & Motility studies	☐	☐	_____	_____
Endoscopy	☐	☐	_____	_____
Esophagram or Swallow study	☐	☐	_____	_____
Other: _____			_____	_____

Please indicate if you have any of the following:

	Yes	Date
LVAD	☐	_____
Pacemaker	☐	_____
Defibrillator	☐	_____

Family Medical History

Relationship	Name	Anesthesia problems	Asthma	Autoimmune disease(s)	Coronary artery disease	Crohn's disease	Clotting disorder	COPD	Cancer	Depression	Diabetes	Heart disease	Hyperlipidemia	Hypertension	Inflammatory bowel disease	Kidney disease	Obesity	Sleep apnea	Stroke	Colon cancer	Gallbladder disease	Ulcerative colitis
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						

Unknown or No known problems ☐

Other family history (Examples: grandmother with breast cancer, aunt with heart disease)

Family Member	**Disease**
_____	_____
_____	_____
_____	_____

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Social History

	Yes	No	
Do you currently smoke cigarettes?	☐	☐	Packs/day _____
Have you ever smoked?	☐	☐	Year you quit _____
Do you drink alcohol?	☐	☐	Drinks/week _____
Have you ever been treated for alcoholism?	☐	☐	
Have you ever used intravenous drugs?	☐	☐	
Are you currently employed?	☐	☐	Occupation _____
Do you have children?	☐	☐	
Do you exercise frequently?	☐	☐	How often? _____

What is your marital status?

☐ Single
☐ Married/Partnered
☐ Divorced
☐ Widowed

Other comments? _____

_____

Would you like to sign up for MyChart today?

Manage your health, your way, using MyChart. It's an online tool designed to help you stay on track to a healthier you by providing secure anytime/anywhere access from your computer, tablet or smartphone.

☐ Decline ☐ Already in Use ☐ Enroll today

Patient Signature _____ Date _____

For Office Use Only:

BP _____ Wt _____
HR _____ Ht _____
Temp _____ RR _____
SPO2 _____

Reviewed by _____ MD Date _____

Entered to EMR by _____ Date _____