

# Baylor Family Medicine

3701 Kirby, Suite 100, Houston, TX 77098  
tele 713-798-7700 fax 713-798-7775



Additional office at **Baylor Clinic**, 6620 Main St. Suite 1250

Check here if you submitted your health information through MyChart.

**Patient Information** Date: \_\_\_\_\_

DR. LIC. #: \_\_\_\_\_ SOC. SEC. #: \_\_\_\_\_ Referred by: \_\_\_\_\_

Title: \_\_\_\_\_ Name: \_\_\_\_\_ Male Female Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle) (Circle One)

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Language preference: \_\_\_\_\_ By what name would you like to be called? \_\_\_\_\_

Blindness/Severe Vision problems? Yes No Deafness/Severe Hearing problems? Yes No

Race \_\_\_\_\_  Hispanic  Non-Hispanic

**Employer** \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Bus. Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Parent/Guardian Information**

Parent/Guardian Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
(If patient is over 18, parent / guardian must have the patient sign a medical records release to obtain clinical information)

**Emergency Contact** \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

## **Insurance Information**

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_

### ••• NO SHOW POLICY •••

If you cannot keep your scheduled appointment, we require that you notify the clinic as soon as possible. A \$20.00 no-show fee will be charged if notice is not received 24 hours in advance. Your cancellation allows us to serve patients who may not otherwise have been seen. Several no-show appointments will result in patients being terminated from Baylor Family Medicine.

**PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT**

# Health History Questionnaire

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthplace \_\_\_\_\_ Education Level \_\_\_\_\_ Occupation \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Committed relationship \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

**MEDICAL HISTORY** Please check conditions you have now, or have had in the past. **Or list below.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Bleeding Disorder  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Prostate Problem   | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Thyroid Problem    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> HIV/AIDS         | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Alcohol/drug Abuse |

**HOSPITALIZATIONS** List all times in the hospital, for illness or surgery, beginning with the most recent.

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Physician</u>

**MEDICATIONS, VITAMINS, SUPPLEMENTS**

Our staff will enter your prescription medications into our electronic medical record, so please have that information ready. Circle the following non-prescription medications that you use:

- |               |                     |              |                       |
|---------------|---------------------|--------------|-----------------------|
| Laxatives     | Antacids            | Aspirin      | Ibuprofen or Naproxen |
| Decongestants | Allergy Pills       | Nasal Sprays | Natural Hormones      |
| Vitamins      | Herbs (Please list) | Supplements  | Other _____           |

**ALLERGIES** If you are allergic to any of the following, please describe the reaction you had.

Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_ Other \_\_\_\_\_

**LIFESTYLES AFFECTING HEALTH**

**Weight** Now \_\_\_\_\_ 1 year ago \_\_\_\_\_ Desired \_\_\_\_\_  
**Seat belt Use** 80-100% \_\_\_\_\_ 50-80% \_\_\_\_\_ Less than 50% \_\_\_\_\_  
**Caffeine** Drinks per day \_\_\_\_\_ **Special diet?** \_\_\_\_\_  
**Exercise** Type: \_\_\_\_\_ Frequency, distance or amount: \_\_\_\_\_

**Tobacco Use** Circle one Never Currently Quit (? YEAR \_\_\_\_\_) Second-hand Smoke  
 Circle type Cigarettes (Packs/day \_\_\_\_\_) Cigars Pipes Snuff Chewing tobacco

**Alcohol Use** Circle one No Yes (if yes, answer questions below)  
 Circle type Shots of liquor Wine Beer  
 Circle amount 0-6 drinks/week 7-14 drinks/week Over 14/week

Patient Name \_\_\_\_\_

Please Complete Back Of Page ►►►

**FAMILY HISTORY**

Family History	If Living		If Deceased		Disease	√	Relationship of relative
	Current Age	Health	Age at Death	Cause			
					Allergies		
Father					Asthma		
					Arthritis		
Mother					Glaucoma		
					Cancer-What kind?		
1. Brother/Sister <i>(circle one)</i>					Tuberculosis		
2. Brother/Sister					Diabetes		
					Heart Trouble		
3. Brother/Sister					High Blood Pressure		
					Stroke		
4. Brother/Sister					High cholesterol		
					Stomach ulcers		
Spouse					Epilepsy/Seizures		
					Substance Abuse		
1. Son/Daughter <i>(circle one)</i>					Anxiety		
					Depression		
2. Son/Daughter					Suicide		
					Kidney Trouble		
3. Son/Daughter					Birth Defects		
					Sickle Cell Anemia		
4. Son/Daughter					Mental Retardation		
					Thyroid problems		

**PREVENTIVE SERVICES** List the date you last had these preventive medicine services or tests.

Physical examination: \_\_\_\_\_ Physician: \_\_\_\_\_

**Heart Disease Prevention:**

High cholesterol: Lipid profile \_\_\_\_\_

**Cancer Screening:**

Breast cancer: Mammogram \_\_\_\_\_

Cervical cancer: PAP smear \_\_\_\_\_

Colon cancer: Colonoscopy \_\_\_\_\_ OR stool test \_\_\_\_\_ plus flexible sigmoidoscopy \_\_\_\_\_

Prostate cancer: PSA (prostate specific antigen) \_\_\_\_\_

**Infectious Disease Prevention:** (List year of most recent immunization)

MMR \_\_\_\_\_ Tetanus \_\_\_\_\_ Hepatitis B \_\_\_\_\_

Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ Hepatitis A \_\_\_\_\_

**Osteoporosis Screening:**

DEXA Scan (bone density test) \_\_\_\_\_

**MENSTRUAL HISTORY**

Age at onset \_\_\_\_\_

Cycle (from start to start) \_\_\_\_\_ days

Date of last period \_\_\_\_\_

If post-menopausal, age at last period \_\_\_\_\_

Usual duration of flow \_\_\_\_\_ days

Flow is: Heavy \_\_\_ Medium \_\_\_ Light \_\_\_ Pain or cramp? \_\_\_\_\_

Periods irregular? \_\_\_\_\_

Have had vaginal infections or frequent discharge? \_\_\_\_\_

Taking birth control pills? \_\_\_\_\_

Have an IUD? \_\_\_\_\_ Have had abnormal PAP? \_\_\_\_\_

Pregnancies Total number \_\_\_\_\_

Number of children born alive? \_\_\_\_\_

Please Complete Back Of Page ►►►

Patient Name \_\_\_\_\_

**CURRENT SYMPTOMS:**

Please circle those symptoms you are currently experiencing within the last **TWO WEEKS**.

Please understand that all concerns may not be addressed due to limitations of your provider's schedule.

**General:**

loss of appetite  
chills  
fatigue  
fevers  
feeling lousy  
sleep disorder  
sweats  
weight loss

**Eyes:**

blurred vision  
color blindness  
contacts/glasses  
double vision  
discharge  
eye pain  
irritation  
yellow eyes  
light sensitivity  
redness  
visual disturbance  
vision loss

**Ear/Nose/Throat:**

ear drainage  
earaches  
nose bleeds  
facial trauma  
hearing loss  
hoarseness  
nasal congestion  
snoring  
sore mouth  
sore throat  
ear ringing  
voice change

**Cardiovascular:**

chest pain  
chest pressure  
calf pain with walking  
difficulty breathing  
chest discomfort with exertion  
fatigue  
irregular heart beats  
lower extremity swelling  
lightheadedness  
short breath with laying  
palpitations  
fainting

**Respiratory:**

cough  
short breath at rest  
short breath with exertion  
coughing blood  
pleurisy  
sputum  
wheezing

**Gastrointestinal:**

difficulty swallowing  
painful swallowing  
indigestion  
reflux symptoms  
nausea  
vomiting  
change in bowel habits  
black tarry stool  
diarrhea  
constipation  
abdominal pain  
jaundice  
gas/bloating

**Genito-urinary:**

decreased stream  
painful urination  
frequency  
blood in urine  
hesitancy  
urinating at night  
urinary incontinence  
abnormal menstrual periods  
genital lesions  
hot flashes  
pelvic pain  
sexual problems  
vaginal discharge  
erectile dysfunction  
genital lesions  
penile discharge  
sexual problems

**Skin/Breast:**

breast lump  
breast tenderness  
changed mole  
dryness  
hair changes  
nipple discharge  
itchy skin  
rash  
skin color change  
skin lesion(s)

**Musculoskeletal:**

joint pains  
back pain  
bone pain  
joint swelling  
leg pain at night  
leg pain with exertion  
muscle cramps  
muscle weakness  
neck pain  
stiff joints

**Neurology:**

coordination problems  
difficulty walking  
dizziness  
frequent falls  
gait problems  
headaches  
memory problems  
numbness  
seizures  
speech problems  
transient blindness  
tremor  
vertigo  
weakness

**Psychiatric:**

abusive relationship  
aggressive behavior  
loss of appetite  
anxiety  
behavior problems  
confusion  
depression  
excessive alcohol consumption  
hallucinations  
illegal drug usage  
learning difficulty  
mood swings  
paranoia  
repetitive activity  
school difficulties  
school phobia  
separation anxiety  
sexual difficulty  
sleep disturbance  
suicidal thoughts

**Endocrine:**

urinating a lot  
drinking a lot  
poor wound healing  
eating a lot  
itchy skin  
skin dryness  
weight  
fertility problems  
temperature intolerance

**Blood/Lymph:**

bleeding  
easy bruising  
swollen lymph nodes

**Allergic:**

anaphylaxis  
hay fever  
hives

## Baylor Family Medicine Financial Policy

To our patients:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is supplied:

The patient or their guarantor is responsible for payment for services provided by **BAYLOR FAMILY MEDICINE** at the time of service. The only exception is if BAYLOR FAMILY MEDICINE has contracted with your HMO/PPO/POS, Medicaid, or Medicare to accept the insurance payment as payment in full after all deductibles have been met and all co-pays has been paid.

We will furnish you with a copy of your bill at each visit, which contains all the information necessary for you to bill your insurance carrier. Charges for an office visit range from \$30 to \$200 +. Additional services such as laboratory and radiology are an additional charge and you will be billed separately.

### HMO/PPO/POS or other Contracted Insurance Coverage:

If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card. Failure to provide this will result in your paying the full amount of the visit at the time of service. Payment of your deductible, co-payment and/or non-covered service is expected at the time of service.

### MEDICAID:

If you have Medicaid coverage, we must make a copy of your Medicaid card at each visit. If you have pending Medicaid coverage, we require payment for the services at the time of your visit. If, within three months after your visit, you provide a retroactive Medicaid card that covers that date of service, we will refund your payment after Medicaid reimburses us for your visit.

### MEDICARE:

Our physicians are participating Medicare providers. Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their **allowable** charges after **you pay your annual deductible** for the calendar year. If you have supplemental insurance we require a copy of your insurance card.

## AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

**In the event that my insurance company denies payment for services rendered, I accept responsibility for the payment due depending on my insurance company's contract with Baylor Family Medicine.**

**In the event that I am not covered by insurance, I understand that I am responsible for payment in full.**

**I hereby authorize Baylor Family Medicine to release any information acquired in the course of my examination or treatment that may be necessary to process my claim. In consideration of services rendered, I hereby authorize payment, not to exceed reasonable and customary charges, directly to Baylor Family Medicine (TXN# 74-1613878).**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_

**Date:** \_\_\_\_\_