BAYLOR Medical Center at Frisco

Past Medical History

Information Source: ☐ Patient ☐ Spouse ☐ Parent
Select All That Apply ☐ Legal Guardian

Scheduled Procedure: _____

Date of Procedure: ____/____/____ mm/dd/yy

Best Number to Reach You: (____) ____-____ Ext: _____

Primary Language: ☐ English ☐ Spanish Other: _____
Interpreter Needed? ☐ Yes ☐ No

Vision Difficulties? ☐ Yes ☐ No Comment: _____

Hearing Loss? ☐ Yes ☐ No Comment: _____

History of Surgery? ☐ Yes ☐ No
If Yes, Please List _____

Implanted Devices? ☐ Yes ☐ No Type: _____

Other Hospitalization? ☐ Yes ☐ No Comment: _____

Problems with Anesthesia? ☐ Yes ☐ No Comment: _____

Malignant Hyperthermia? ☐ Yes ☐ No

Family Problems
with Anesthesia? ☐ Yes ☐ No Comment: _____

Respiratory Problems? ☐ Yes ☐ No Comment: _____
Last Chest X-Ray Date: _____

Cardiac Problems? ☐ Yes ☐ No Comment: _____
Do You Have a Pacemaker? ☐ Yes ☐ No
Ever Had Chest Pain? ☐ Yes ☐ No Comment: _____
Heart Attack? ☐ Yes ☐ No Comment: _____
Date of Last EKG: ____/____/____ mm/dd/yy
Date of Last Stress Test: ____/____/____ mm/dd/yy
Cardiologist Name: _____
Cardiologist Number: (____) ____-____ Ext: _____

History of Blood Clots:	☐ Yes	☐ No	Comment: _____
Neurological Problems?	☐ Yes	☐ No	Comment: _____
Eyes/Ears/Nose/Throat Problems?	☐ Yes	☐ No	Comment: _____
Gastrointestinal Problems?	☐ Yes	☐ No	Comment: _____
Have You Ever Had Hepititis?	☐ Yes	☐ No	Type: _____
Urinary Problems?	☐ Yes	☐ No	Comment: _____
Reproductive Problems?	☐ Yes	☐ No	Comment: _____
Last Menstrual Cycle?	_____		
Birth Control Method:	_____		
Previous Pregnancy?	☐ Yes	☐ No	☐ Not Applicable
Are You Pregnant Now?	☐ Yes	☐ No	☐ Not Applicable
Are You Breastfeeding?	☐ Yes	☐ No	☐ Not Applicable
Endocrine Problems? (Ex: Thyroid, Diabetes)	☐ Yes	☐ No	Comment: _____
Musculoskeletal Problems?	☐ Yes	☐ No	Comment: _____
Assistive Device Utilized:	☐ Cane	☐ Roll-A-Bout	☐ Walker
Select All That Apply	☐ Crutches	☐ Rolling Walker	☐ Wheelchair
	☐ Prosthesis	☐ Not Applicable	
Do You Have Chronic Pain?	☐ Yes	☐ No	
Skin Problems?	☐ Yes	☐ No	Comment: _____
Tattoos?	☐ Yes	☐ No	
Piercings?	☐ Yes	☐ No	
Autoimmune Problems?	☐ Yes	☐ No	Comment: _____
HIV Positive?	☐ Yes	☐ No	
Ever Had Cancer?	☐ Yes	☐ No	Comment: _____
History of Multi Drug Resistance Organism? (MRSA, VRE, CDIFF)	☐ Yes	☐ No	Comment: _____
Bleeding/Clotting Problems?	☐ Yes	☐ No	Comment: _____
Hematologist Name:	_____		
Hematologist Number:	( ) -		Ext: _____
Ever had a transfusion?	☐ Yes	☐ No	

Blood Transfusion Reaction? ☐ Yes ☐ No Comment: _____

Psychsocial Problems? ☐ Yes ☐ No Comment: _____

Religious/Cultural Beliefs
Affecting Healthcare? _____

Tobacco Use or History Of? ☐ Yes ☐ No
Tabacco Type Used: ☐ Cigarettes ☐ Cigars ☐ Chew
Select All That Apply ☐ Other
Average Daily Usage: ☐ One or Two ☐ Three to Five ☐ Six+
Date Quit? ____/____/____ mm/dd/yy ☐ Have Not Quit

Alcohol Use or History Of? ☐ Yes ☐ No
Alcohol Type Used: ☐ Wine ☐ Beer ☐ Liquor
Select All That Apply ☐ Other
Average Daily Drinks: ☐ One or Two ☐ Three to Five ☐ Six+

Substance Abuse? ☐ Yes ☐ No

Other Medical History or Comments: _____

Known Family Medical Problems: _____

Regular Excercise? ☐ Yes ☐ No
Excercise Type? (Ex: Aerobics, Running, etc) _____
Daily Amount of Excercise? _____
Shortness of Breath or Chest Pain? ☐ Yes ☐ No

Primary Care Physician Name: _____

Primary Care Physician Number: (____)_____-_____ Ext: _____

Pediatric Only:

Delivery or Birth Complications? ☐ Yes ☐ No Comment: _____

Birth Defects? ☐ Yes ☐ No Comment: _____

Genetic Disorder? ☐ Yes ☐ No Comment: _____

Developmental/Learning Delays? ☐ Yes ☐ No Comment: _____

Exposure to Smoke? ☐ Yes ☐ No