



New Patient General Intake Form

BCM has developed this **General Intake Form**, which is common to all of our offices. Your answers will be accessible at any future BCM office visit in your electronic chart. To provide additional information important to your appointment today, each department has created a **Specialty Intake Form** with questions specific to their department, so please ensure you fill this out as well.

Patient Name _____ Date of Birth _____ Today's Date _____

ALLERGIES Please list any allergies or reactions to medication(s):

MEDICAL HISTORY Please check the boxes to indicate if you have had any of these conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Migraine/Headaches |
| <input type="checkbox"/> Allergies, Seasonal | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Reflux or GERD |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots/ DVT | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Transient Ischemic Attack |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> HIV | <input type="checkbox"/> Ulcers of Stomach |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> UTIs – Recurrent |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> IV Drug Use | <input type="checkbox"/> Valve Problem /Murmur |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Varicose Veins/Phlebitis |

Please specify any other medical condition(s) that you have now or have had in the past:

SURGICAL HISTORY

Please use the space below to explain your past surgical procedures.

FAMILY HISTORY Please write in any IMMEDIATE family member (i.e. mother) who has or has had the following conditions in the space provided. Include their age when first diagnosed.

Check here if you were ADOPTED

Condition	Family Member	Age	Condition	Family Member	Age
Breast Cancer			CVA/Stroke		
Colon Cancer			Diabetes		
Ovarian Cancer			High Cholesterol		
Prostate Cancer			High Blood Pressure		
Melanoma			Other		
Depression					
Heart Attack/Bypass					

LIFESTYLE CHOICES**Tobacco**

Do you smoke? Yes No Quit

Do you use smokeless tobacco? Yes No Quit

How many years? _____

How many packs/cans per day? _____

Are you ready to quit? Yes No

If you quit using tobacco, when did you stop? _____

Alcohol

Do you consume alcohol? Yes No Quit

How many drinks containing alcohol do you consume in a week? _____

(1 drink = 1 glass of wine = 1 can of beer = 1 shot of liquor)

Please also complete the **Specialty Intake Form** for this office.

Thank you for choosing Baylor College of Medicine.