(Patient Label)
Name:
DOB:

Baylor Scott & White
HILLCREST INTERNAL MEDICINE AND SENIOR HEALTH CENTER
WACO

Are you experiencing any of the following?

Constitutional

Fever	Yes	No
Chills	Yes	No
Unexplained Weight Loss	Yes	No
Fatigue	Yes	No
Sweating	Yes	No
Weakness	Yes	No

Skin

Rash	Yes	No
Itching	Yes	No

HENT

Headaches	Yes	No
Hearing Loss	Yes	No
Ringing in Ears	Yes	No
Ear Pain	Yes	No
Ear Discharge	Yes	No
Nosebleeds	Yes	No
Congestion	Yes	No
Wheezing	Yes	No
Sore Throat	Yes	No

Eyes

Blurry Vision	Yes	No
Double Vision	Yes	No
Light Sensitivity	Yes	No
Eye Pain	Yes	No
Eye Discharge	Yes	No
Eye Redness	Yes	No

Gastrointestinal

Heartburn	Yes	No
Nausea/Vomiting	Yes	No
Abdominal Pain	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in Stool	Yes	No
Dark Tarry Stool	Yes	No

Genitourinary

Painful urination	Yes	No
Urgency	Yes	No
Frequency	Yes	No
Blood in Urine	Yes	No
Flank Pain	Yes	No

Musculoskeletal

Muscle Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Joint Pain	Yes	No
Unexplained Falls	Yes	No
Joint Swelling	Yes	No

Cardiovascular

Chest Pain	Yes	No
Palpitations	Yes	No
Leg Cramping	Yes	No
Leg Swelling	Yes	No

Endo/HEME/Allergies

Easily Bruise	Yes	No
Allergies	Yes	No
Excessive Thirst	Yes	No
Swollen Lymph Nodes	Yes	No

Psychiatric

Depression	Yes	No
Suicidal Ideas	Yes	No
Substance Abuse	Yes	No
Hallucinations	Yes	No
Anxiety	Yes	No
Difficulty sleeping	Yes	No
Memory Loss	Yes	No

Neurological

Dizziness	Yes	No
Tingling	Yes	No
Tremor	Yes	No
Sensory Change	Yes	No
Speech Change	Yes	No
Focal Weakness	Yes	No
Seizures	Yes	No
Loss of Consciousness	Yes	No

Pulmonary

Shortness of breath	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Hemoptysis	Yes	No

Please Clarify any Yes Answers:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Patient Medical History

(circle all that you currently have and/or have previously had)

Heart Problems	Neurological	Psychological	Gastrointestinal
• Congestive Heart Failure • Deep Vein Thrombosis • Heart Attack • Heart Murmur • High Blood Pressure • High Cholesterol • Neuropathy • Irregular Heartbeat • Anemia/Clotting Disorder • Other:	• Alzheimer's disease • Parkinson's disease • Migraines • Seizure Disorder • Stroke • Dementia • TIA • Other	• Anxiety • Depression • Schizophrenia • Bipolar **Cancer** Type, stage &Location	• Cirrhosis • Gastric Ulcer • GERD (acid reflux) • Rectal Bleeding • Hemorrhoids • Diverticulitis • Crohn's Disease Ulcerative Colitis • Other:
Endocrine Problems	**Urinary Problems**	**Lung Problems**	**Musculoskeletal**
• Diabetes Type 1 (juvenile) • Diabetes Type II (Adult onset) • Hyper/hypothyroid disorder • Hyper/Hypocalcaemia • Other:	• Kidney Infection • Kidney Stones • Kidney Disease/Failure • Prostate Enlargement • Other:	• Asthma • COPD • Emphysema • Pneumonia • Pulmonary Embolism • Sleep Apnea • Allergies • Other:	• Osteoarthritis • Osteoporosis • Rheumatoid Arthritis **Infections:** Hepatitis B Hepatitis C HIV+

Family Medical History

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Siblings: _____

Children: _____

Surgical History **(Please list all surgeries, year performed and surgeon)**

_____

_____

Do you have any surgical implants, pacemakers or devices? Y/N

If yes, please list surgeon, device and year placed: _____
If applicable, please provide staff with your implant device card.

Social History Marital Status: Number of Children: Occupation:

(Patient Label)
Name:
DOB:

Female Patients ONLY:

Are You Pregnant? Y/N Date of Last Menstrual Period:_____ Age of Menopause:_____

Substance Use (past and present)

Tobacco Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Alcohol Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Drugs Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Medication List

Medication Name	Dosage	Times Per Day	Reason

Please include all prescriptions, over-the-counter, vitamins and herbal supplements

Preferred Pharmacy:

Allergies:

Circle if you are allergic to the following:

Penicillin Codeine Sulfa Drugs Latex Iodine

Please list any other foods and/or medications you are allergic to and your reaction to them:

Allergy	**Reaction**

(Patient Label)
Name:
DOB:

Patient Agreement & Behavioral Contract

I understand that in order for me as a patient to benefit from health care provided to me, I am responsible for participating in the determination of my medical care plans and to follow recommended treatment plans. I also understand that a good patient/physician/medical staff relationship is based on mutual respect and trust.

Patient Responsibilities:

1. Refrain from harassment and/or intimidation of staff or providers in any form (via in-person, over- the-phone or electronic communication (i.e MyBswhealth)).

   Use of profanity, harassment of any type, or actions deemed inappropriate toward Baylor Scott & White staff or providers are regarded very seriously and is absolutely unacceptable behavior in Hillcrest Internal Medicine & Senior Health Clinics. If this should occur, you will be asked to refrain from such language or actions. If you choose not to comply, other actions outlined below will be taken.
2. Exhibit compliance with prescribed regimen of health care.

   To ensure the best treatment environment, you must adhere to physician's orders and all care plans as prescribed by the physician or advanced practice professional.

If the above agreement is violated:

- I may be subject to termination of my privileges to be a Hillcrest Internal Medicine & Senior Health Clinic patient and possibly other Baylor Scott & White Facilities.
- I will not be allowed on the premises of Hillcrest Internal Medicine & Senior Health Clinic.
- Baylor Scott & White Security and/or Waco Law Enforcement will be immediately contacted in any disruption is caused at the Hillcrest Internal Medicine & Senior Health Clinic.

My continued ability to receive medical care and treatment will be contingent upon my adherence to this agreement. I understand that my signature indicates that I am in agreement with the previously outlined patient responsibilities and understand any consequences that occur due to violation of this agreement.

_____ _____

Patient/Guarantor Signature Today's Date

_____

Relationship to Patient

(Patient Label)
Name:
DOB:

Narcotics/Controlled Substances Prescription Notice

Our office does not routinely prescribe narcotics on a long term basis, nor do we administer narcotics by injection at the clinic. No narcotic medication is kept on site. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management clinic or, if the pain is severe, with the local emergency department. Narcotic prescriptions will not be refilled after office hours or on weekends.

It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore, patients who do seek narcotic prescriptions through our office agree that, unless otherwise indicated by our physicians, we are to be the sole prescribing physicians for the patient. Furthermore, patients desiring prescriptions from our clinic agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine that multiple physicians are ordering prescriptions of pain medications, we will immediately cease all orders for such treatments from our office.

Prescription Policy

- The patient will be given a choice to designate a pharmacy to be used (see signature page). All prescriptions should then be filled through this pharmacy only,
- We ask that you contact your designated pharmacy for all refill requests even if you have no refills remaining. Please allow for a 72-hour turnaround time on all prescriptions.
- We do not refill prescriptions on weekends of holidays. Be sure to submit your request before 2:00pm on Thursday for prescriptions you will be out of over the weekend.
- We will not refill prescriptions for patients not seen tin the past 6 months by a provider in our office.
- We will not refill prescriptions for patients who have missed appointments until you are seen by one of our providers.
- Prescriptions requests submitted after 2:00pm will not be handled until the next business day.
- Medications will only be sent in to the designated pharmacy.
- Medications are to be taken according to directions. No early refills will be granted.
- It is the patient's responsibility to keep medications safe. Lost or damaged medications may not be refilled. If medication is stolen, you must file a police report and submit the number for verification to our office.

Acknowledgment of prescription policies

I have read and understand the policies of this office regarding prescriptions and nicotine use. I agree to the terms involved in the Prescription and Narcotic Policies and have received a copy of these policies.

_____ _____

Patient/Guarantor Signature Today's Date

_____

Relationship to Patient