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:

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