BHFS Medical & Behavioral Services
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Lewisville, TX 75057
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Full Name:_____ Date:_____

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

What is the reason for your visit? (Be as specific as possible)

Do you have any other symptoms? (Be as specific as possible)

How would you like to receive medical information from us (ex: lab results, medication refills)?

☐ Phone Call ☐ Text ☐ Email ☐ No Preference

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS ☐ NO MEDICATION

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on the last page

YOUR CARE TEAM: Please provide the names of any other providers that you currently receive care from.

Healthcare Provider's Name	Specialty

PSYCHATRIC HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Anxiety			
Depression			
Bipolar			
Suicidal Thoughts			
ADHD			

Autism			
Schizophrenia			
Obsessive Compulsive Disorder			
Hallucinations (Auditory, Visual)			
Other:			

PAST MEDICAL HISTORY: Please check all that apply.

☐ No medical problems

	Abnormal pap smear
	Anemia
	Asthma
	Atrial fibrillation
	Breast cancer
	Cervical cancer
	Chicken pox
	Chronic Back pain
	Colon cancer
	Deep Vein Thrombosis

	GERD
	Gestational Diabetes
	GI bleed
	Gout
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Hypertension
	Hyperthyroidism
	Hypothyroidism

	Kidney Stone
	Heart attack
	Kidney Disease
	Kidney Failure
	Seizures
	Skin Cancer
	Stroke
	Ulcers

PAST SURGICAL HISTORY: Please check all that apply.

☐ No surgical history

	Abdominal aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Brain Surgery
	Breast Biopsy R/L
	Breast Enhancement
	Breast Surgery R/L
	CABG-Heart bypass
	Cardiac catheterization
	Carotid Endarterectomy
	Carpal Tunnel surgery R/L

	Cataract Surgery R/L
	Cerebral Aneurysm
	Colon Surgery
	Gall Bladder removal
	Heart Transplant
	Hip Surgery R/L
	Hysterectomy
	Hysterectomy with ovaries removed
	Kidney removal R/L
	Kidney Transplant
	Knee arthroscopy
	Knee Surgery R/L

	Liver Transplant
	Lung Transplant
	Mastectomy (breast removal) R/L
	Neck Surgery
	Previous C-section
	Shoulder Surgery R/L
	Sinus Surgery
	Tonsillectomy
	Tubal ligation (tubes tied)
	Valve replacement
	Other

OTHER MEDICAL HISTORY - Please use this space to list any other medical diagnoses/surgeries you may have that is not listed above

OTHER FAMILY HISTORY - Please check all that apply: ☐ No Family history

	none	Alcohol abuse	Alzheimer's	Asthma	Autoimmune	Breast cancer	Cancer	Colon cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

SOCIAL HISTORY

Occupation *(or prior occupation)*:	☐ Currently working ☐ Retired ☐ Unemployed ☐ Disabled
Employer:	Highest Degree:
If you are currently in school, please indicate the grade and school you are attending: Grade: School:	
Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Do you have children? ☐ Yes ☐ No	If yes, how many?
Who do you live with at home?	
SLEEP: How many hours, on average, do you sleep at night *(or during the day, if working night shift)*	
DIET: How would you rate your diet? ☐ Good ☐ Fair ☐ Poor	

TOBACCO USE		
Do you smoke cigarettes? *(If you never smoked, please move to Alcohol /Drug Use)* ☐ Yes ☐ No		
Current: Packs/day:_____ # of Years: _____	***Past:*** Quit Date:_____ Packs/day:_____# of Years: _____	
Other Tobacco Use: ☐ Pipe ☐ Cigar ☐ Other:_____		
ALCOHOL/DRUG USE		
Do you drink alcohol? ☐ Yes ☐ N	☐ Beer ☐ Wine ☐ Liquor	# of drinks/week:_____
Do you use marijuana or recreational drugs? ☐ Yes ☐ No	Have you ever used needles to inject drugs? ☐ Yes ☐ No	
Please list all drugs you are currently using, if any: _____		
Please list all drugs you used in the past, if any: _____		
SUICIDAL HISTORY		
Have you ever attempted suicide? ☐ Yes ☐ No If yes, when was the most recent attempt?		

WOMEN'S HEALTH HISTORY:

Date of Last Menstrual Period	
# of Pregnancies	
# of Miscarriages	
# of Abortions	

PREVENTATIVE CARE: Please list the dates of your most recent tests

Type of Test/Procedure	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
For Women Only		
Osteoporosis Test/DEXA		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		

Last Prostate exam		
Prostate-Specific Antigen Test		

IMMUNZATIONS: **Please enter the dates of your most recent vaccinations.**

Tetanus/TDaP/Td:_____ Human Papilloma Vaccination (HPV)/Gardasil: _____
Influenza Vaccination: _____

Please feel free to use this space to address any other medical information/concerns.