Baylor Scott & White
RESIDENCY AT DALLAS

To Our Patients

Welcome to the Baylor Scott & White Residency at Dallas. This Clinic functions as an extension to the Graduate Medical Education program for physicians that recently graduated from medical school. The Clinic's goal is to provide our patients with high quality care while educating the resident physician to care for patients in the outpatient setting.

Since resident physicians are in training, please expect appointments to last longer than those in a traditional physician's office. The resident physicians often consult with a supervising physician about your care before giving the medical assistant orders or the next appointment. Please be patient for we are working as fast as we can to process your discharge instructions.

We ask that you call the Clinic early for requests to speak to your physician. The resident physicians are usually in the Clinic one day a week. However, the Clinic will make every effort to accommodate your medical needs while your doctor is not in the Clinic. Patients are seen by appointment only as this is not a walk-in clinic; however, we have urgent appointments available for some of our specialty clinics.

Clinic telephone number: 214-820-3275

Clinic fax number: 214-820-2530

Clinic hours: Monday – Thursday 8:30 am – 5:00 pm and Friday 8:30 am – 12:30 pm and closed during most holidays.

*Please note, when Dallas Independent School District closes for inclement (bad) weather, the Clinic is closed and your appointment will be rescheduled.

Appointments: We request you arrive 15 minutes prior to your scheduled appointment to complete the check-in process and reduce the waiting time for all our patients.

Prescription Refills: Please call your pharmacy for a refill request **2 weeks** before you run out of medicine. This will provide your doctor plenty of time to review and process your refill request.

Thank you for your understanding and choosing the Baylor Scott & White Residency at Dallas for your health care needs.

Sincerely,

The Baylor Scott & White Residency at Dallas Team

Prenatal and Obstetrical Questionnaire

Date_____

Name	Date of Birth	Age	Occupation	Marital Status	Ethnic Origin ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ Indian ☐ European ☐ Other
Home Address Street_____ Apartment number:_____ City, State, Zip Code_____	Home Phone Cell Phone	Occupation, Employer and Work Address Employer_____ Work Address_____ Work Phone_____			

Have you been seen in this clinic before? _____ If yes, when? _____
Social Security Number: _____
Private Insurance: _____ Name of insured: _____
Policy or Group Number_____ Insured's Social Security Number _____ Deductible: _____
Medicaid Number_____ Type of Medicaid _____

What was the first day of your last menstrual period? _____

Was the period: ☐ NORMAL or ☐ ABNORMAL?
Are you: ☐ CERTAIN or ☐ UNCERTAIN of this date?

How old were you when you had your first period? _____

Are your periods normally: ☐ REGULAR or ☐ IRREGULAR?

How often do you usually get your period? Every _____ days.
For how long do you usually flow? For _____ days.

Pain or cramps with your period? ☐ YES ☐ NO ☐ SOMETIMES.

_____How many times have you been pregnant?
_____How many live births?
_____How many miscarriages or abortions?
_____How many children are at home?

Describe the last form of birth control you used before pregnancy, and when you stopped it.

If you used birth control pills in the past, when did you stop taking them? _____

Normal Weight _____ Height _____

Weight just before pregnancy _____

Please list all past pregnancies.

PREGNANCY NUMBER	DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	LENGTH OF LABOR	ANESTHESIA	HOSPITAL	SEX OF BABY	WEIGHT OF BABY	COMPLICATIONS
1									
2									
3									
4									
5									

During THIS pregnancy, have you experienced any of the following?

Have you been told by a doctor you are having twins or any abnormal testing? _____

YES	NO	CONDITION	YES	NO	CONDITION
		NAUSEA OR VOMITING?			DO YOU HAVE PAIN NOW? WHERE: _____
		VAGINAL BLEEDING?			IS YOUR PAIN CONSTANT?
		PAINFUL URINATION?			DOES YOUR PAIN COME AND GO?
		VAGINAL DISCHARGE			WHAT MAKES YOUR PAIN BETTER? WORSE?
		ABDOMINAL PAIN			

Please explain any yes answers:

During PREVIOUS pregnancies, did you experience any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		A STILLBORN BABY?			A BABY WITH JAUNDICE
		A BIRTH DEFECT OR ABNORMALITY?			EXCESSIVE BLEEDING (HEMORRHAGE) AFTER DELIVERY?
		INFANT DEATH FOLLOWING DELIVERY?			HOSPITALIZATION BEFORE LABOR?
		A PREMATURE BABY?			RHOGAM INJECTIONS
		A BABY WITH A SERIOUS INFECTION?			ANY OTHER UNUSUAL OCCURRENCE?
		A BABY ADMITTED TO THE INTENSIVE CARE UNIT?			

Please explain any yes answers;

Do you have a personal history of any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		GENERAL HEALTH			**EARS**
		OBESITY			EAR INFECTIONS
		UNDERWEIGHT			HEARING LOSS
		ANY CHRONIC ILLNESS			WEAR HEARING AIDS
		MENTAL OR PHYSICAL LIMITATIONS			RUPTURED EAR DRUM
		POOR DENTAL CONDITION			**NOSE**
		HEAD			BROKEN NOSE
		CHRONIC HEADACHES			SINUS INFECTIONS
		MIGRAINE HEADACHES			FREQUENT NOSE BLEEDS
		CONCUSSION OR BLACKOUTS			NASAL SEPTAL DEFECT
		EPILEPSY OR SEIZURES			NOSE SURGERY
		TUMORS			**THROAT**
		EYES			TONSILLITIS OR TONSILLECTOMY
		WEAR GLASSES OR CONTACT LENSES			ADENOIDECTOMY
		BLURRED VISION			STREP THROAT
		POOR NIGHT VISION			LARYNGITIS (LOSS OF VOICE)
		MOVING SPOTS OR BLIND SPOTS			

Please explain any yes answers:

YES	NO	CONDITION	YES	NO	CONDITION
		NECK			**GASTROINTESTINAL (STOMACH)**
		LYMPH NODE ABNORMALITIES			DIABETES
		THYROID PROBLEMS OR SURGERY			ULCERS, STOMACH PROBLEMS
		INJURY FROM ACCIDENT			COLITIS, IRRITABLE BOWEL SYNDROME
		LIMITATION OF MOVEMENT			CHRONIC DIARRHEA
		RESPIRATORY			CHRONIC CONSTIPATION
		LUNG PROBLEMS			EATING DISORDER (BULIMIA, ANOREXIA)
		TUBERCULOSIS (OR INH MEDICATION)			HEMORRHOIDS OR RECTAL PROBLEMS
		RESPIRATORY (Cont)			**GASTROINTESTINAL (STOMACH)**

		POSITIVE PPD (TUBERCULOSIS TEST)			GALL BLADDER PROBLEMS
		PNEUMONIA OR BRONCHITIS			VEGETARIAN
		ASTHMA	**URINARY**		
		PNEUMOTHORAX (COLLAPSED LUNG)			BLADDER INFECTIONS (UTI'S)
CARDIAC (HEART)					KIDNEY INFECTION (PYELONEPHRITIS)
		HEART DISEASE, PROBLEMS, OR IRREGULAR HEART RATE			KIDNEY STONES
		HYPERTENSION (HIGH BLOOD PRESSURE)			BLADDER OR KIDNEY SURGERY
		HYPOTENSION (LOW BLOOD PRESSURE)			LEAKING OF URINE (INCONTINENCE)
		HEART MURMUR			IVP'S (INTRAVENOUS PYELOGRAM)
HEMATOLOGY			**LYMPHATIC**		
		HEPATITIS			ABNORMAL LYMPH NODES
		BLOOD CLOTS OR STROKE			HODGKIN'S DISEASE
		VARICOSE VEINS			ERYTHEMA NODOSUM
		SICKLE CELL DISEASE OR TRAIT			VEGETARIAN
		ABNORMAL BLOOD TYPE (HEMOGLOBINOPATHY)	**NEUROPSYCHIATRIC**		
		BLOOD TRANSFUSION			EMOTIONAL PROBLEMS
		LEUKEMIA			PSYCHIATRIC HOSPITAL
		ANEMIA (LOW BLOOD COUNT OR LOW IRON)			DEPRESSION OR ANXIETY
		HEMORRHAGE (EXCESSIVE BLOOD LOSS)			CHILDHOOD SEXUAL ABUSE
		POSITIVE HIV TEST OR AIDS			MARITAL PROBLEMS
		POSITIVE ANTIBODY SCREEN			SEEING A PSYCHIATRIST, PSYCHOLOGIST

Please explain any yes answers:

YES	NO	CONDITION	YES	NO	CONDITION
GYNECOLOGY			**GYNECOLOGY (Cont)**		
		PROBLEMS WITH BIRTH CONTROL PILLS			MISCARRIAGE
		ABNORMAL PAP SMEAR (DYSPLASIA OR CIN)			ABORTIONS (ELECTIVE)
		COLPOSCOPY (MICROSCOPIC EVALUATION OF THE CERVIX)	**MUSCULOSKELETAL**		
		CRYOSURGERY (FREEZING OF THE CERVIX)			MUSCLE ACHES, PAINS, OR STRAINS
		CONE BIOPSY (REMOVAL OF PART OF THE CERVIX)			BROKEN BONES OR INJURY TO MUSCLES OR BONES
		INFERTILITY WORK-UP			SKELETAL ABNORMALITIES (SCOLIOSIS)
		PAINFUL INTERCOURSE			BIRTH DEFECTS OR GENETIC DEFORMITIES
		SEXUAL MOLESTATION, ABUSE, RAPE			PHYSICAL RESTRICTIONS TO MOVEMENT
		FIBROID TUMORS OF THE UTERUS			CARPAL TUNNEL SYNDROME
		OVARIAN CYSTS			FREQUENTLY SEE A CHIROPRACTER
		RECURRENT (FREQUENT) VAGINAL INFECTIONS	**ALLERGIES**		
		PELVIC INFLAMMATORY DISEASE (PID)			MEDICINE:
		SEXUALLY-TRANSMITTED DISEASE (SYPHILIS, GONORRHEA, CHLAMYDIA, HERPES, TRICHOMONAS)			
		GENITAL WARTS			FOODS:
YES	NO	CONDITION	YES	NO	CONDITION

		OTHER CONDITIONS			
		DO YOU SMOKE OR DIP TOBACCO?			DO YOU DRINK ALCHOLIC BEVERAGES?
		HAVE YOU EVER USED MARIJUANA, SPEED, COCAINE, HEROIN, CRACK, LSD, ACID OR OTHER MIND-ALTERING DRUGS?			DO YOU EAT UNUSUAL SUBSTANCES (STARCH, PAINT, CLAY)?
Please explain any yes answers:					

Have you had any of the following childhood illness or surgeries?

YES	NO	CONDITION	YES	NO	CONDITION
		CHICKENPOX (VARICELLA) (OR WAS VACCINATED)			APPENDIX REMOVED
		MEASLES (RBEOLA) (OR WAS VACCINATED)			BREAST BIOPSY
		RHEUMATIC FEVER			BREAST ENLARGEMENT OR REDUCTION SURGERY
		SCARLET FEVER			ORAL SURGERY
		MUMPS (OR WAS VACCINATED)			PLASTIC SURGERY
		GERMAN MEASLES (RUBELLA) (OR WAS VACCINATED)			LAPAROSCOPY
		GALLBLADDER REMOVAL			D & C (DILATATION AND CURETTAGE)
					ANY OTHER SURGERY?
Please explain any yes answers:					

Does any member of your immediate family have any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		HEART DISEASE OR HEART ATTACK			MUSCULAR DYSTROPHY OR CYSTIC FIBROSIS
		HIGH BLOOD PRESSURE			HUNTINGTON CHOREA
		KIDNEY OR BLADDER DISEASE			TAY-SACHS DISEASE
		TUBERCULOSIS			TWINS OR MULTIPLE BIRTHS
		DIABETES			CANCER
		EMOTIONAL OR MENTAL DISORDER			CHRONIC ILLNESSES
		STROKE, BLOOD CLOTS OR PHLEBITIS			DRUG ABUSE
		BLOOD VARIATIONS (SICKLE CELL, THALASSEMIA)			MAJOR OPERATIONS
		HEMOPHILIA			PREGNANCY COMPLICATIONS
		BIRTH DEFECTS, DOWN SYNDROME, NEURAL TUBE DEFECTS			DID YOUR MOTHER TAKE ANY HORMONES WHILE CARRYING YOU?
Please explain any yes answers:					

List Current Medicines you take: _____

_____

How do you best learn new information? (Check all that apply) **Primary language spoken:** _____

___ Verbal Instruction **___ Written Instruction** **___ Demonstration** **___ Practice**

___ Other: Explain _____

_____

OFFICE USE ONLY:

Accepted Denied Date: _____ Signature: _____

Assign to: 1st year 2nd year 3rd year 4th year Specific: _____

PSYCHOSOCIAL NEEDS ASSESSMENT

The purpose of this assessment is to determine if you may need the assistance of our social service staff. Upon review, you may be referred to our social worker, who may wish to meet with you to discuss some of your answers or concerns.

Please circle the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

1. I have been able to laugh and see the funny side of things. 0 = As much as I always could 1 = Not quite so much now 2 = Definitely not so much now 3 = Not at all	6. Things have been getting on top of me. 3 = Yes most of the time I haven't been able to cope at all 2 = Yes sometimes I haven't been coping as well as usual 1 = No most of the time I have coped quite well 0 = No I have been coping as well as ever
2. I have looked forward with enjoyment to things. 0 = As much as I ever did 1 = Rather less than I used to 2 = Definitely less than I used to 3 = Hardly at all	7. I have been so unhappy, I have had difficulty sleeping. 3 = Yes most of the time I haven't been able to cope at all 2 = Yes sometimes I haven't been coping as well as usual 1 = No most of the time I have coped quite well 0 = No I have been coping as well as ever
3. I have blamed myself unnecessarily when things went wrong. 3 = Yes most of the time 2 = Yes some of the time 1 = Not very often 0 = No never	8. I have felt sad or miserable 3 = Yes most of the time 2 = Yes sometimes 1 = Not very often 0 = No, not at all
4. I have been anxious or worried for no good reason. 0 = No not at all 1 = Hardly ever 2 = Yes sometimes 3 = Yes very often	9. I have been so unhappy that I have been crying. 3 = Yes most of the time 2 = Yes quite often 1 = Only occasionally 0 = No never
5. I have felt scared or panicky for not good reason. 3 = Yes quite a lot 2 = Yes sometimes 1 = No not much 0 = No not at all	10. The thought of harming myself has occurred to me. 3 = Yes quite often 2 = Sometimes 1 = Hardly ever 0 = Never
	_____ TOTAL SCORE

ADDITIONAL COMMENTS:

ASSESSMENT OF NUTRITIONAL STATUS

The purpose of this assessment is to determine if you may need the assistance of our dietician staff. Please answer the following questions and make additional comments below.

YES	NO	SOMETIMES	STATEMENT
			I am taking a prenatal vitamin every day
			I skip meals or regularly go long periods without eating
			I have a history of gestational diabetes
			I have a history of anemia
			I have a history of eating disorders, such as bulimia or anorexia
			I have a history of high blood pressure
			I am currently having problems with nausea and vomiting
			I am currently having problems with constipation or diarrhea
			I am currently having problems with leg cramps
			I am currently having problems with heartburn
			I am currently having problems with milk allergy
			I am currently age 18 or younger
			I am currently craving non-food items such as clay or dirt
			I am currently following a special diet
			I am currently underweight
			I am currently overweight
			I am having problems with not eating enough
			I feel I need individual nutritional counseling

PLEASE PLACE A CHECK (√) BY THE FOODS YOU EAT RGULARLY

__ Non-fat or 1% skim milk	__ Fish	__ Fruit	__ Margarine	__ Water
__ Low-Fat milk	__ Chicken/Turkey	__ Vegetables	__ Mayonnaise	__ Juice
__ Whole milk	__ Lean red meat	__ Grain cereal	__ Salad Dressing	__ Soda
__ Yogurt (Regular or Frozen)	__ Eggs	__ Sugar cereal	__ Nuts	__ Kool-Aid
__ Cottage cheese	__ Beans	__ White bread	__ Cooking Oil	__ Desserts
__ Cheese	__ Hamburger	__ Wheat bread	__ Chocolate	__ Candy
__ "Creames" (ice, sour, cheese, whipped)	__ Hot dogs	__ Brown rice	__ Fast/Fried Foods	__ Cookies
	__ Fried chicken	__ White rice	__ Gravy, sauces	__ Pastries

ADDITIONAL COMMENTS: