Saint Luke's Medical Group
SAINT LUKE'S HEALTH SYSTEM
saint-lukes.org

PATIENT HISTORY QUESTIONNAIRE

DATE: __________________
NAME: ______________________________ **DATE OF BIRTH:** ____________

FAMILY HISTORY: Has any **BLOOD** relative had the following? If so, please indicate that individual's relationship to you (i.e., Mother, Father, etc.)

____________ Mental Illness
____________ Heart Disease
(If heart attack, indicate age of first onset)
____________ Glaucoma
___________ Suicide
___________ Alcoholism
___________ High Cholesterol
___________ High Blood Pressure
___________ Diabetes
_____________Cancer
_____________Stroke
_____________Colon Polyps
_____________Other

SOCIAL HISTORY:

Occupation: ___________________________
Do you smoke? ___________________________
If a former smoker, when did you quit?__________
Do you avoid any foods?:_____________________
Diet (Meals/Day) _____________________
Exercise: (Daily/Weekly)____________ _________
Average salt intake:__________________________
Spouse:_________________________________
Do you drink Alcohol?:______________________
Average Use:_______________________________
Do you use a seat belt?:_____________________
Do you feel safe at home?:___________________
Do you consider yourself at risk for AIDS? ______

PERSONAL HISTORY: Check any illness or condition **YOU** have had or currently have:

______ Rheumatic Fever
______Blood in Stools
______Diabetes
______Anemia
______Hemorrhoids
______Thyroid or Goiter
______Cancer
______Arthritis
______High Cholesterol
______Kidney Stones/Disease
______Osteoporosis
______Depression
______Syphilis/Gonorrhea
______Herpes/Genital Sores
______Pneumonia
______Hay Fever
______Weight change
______Epilepsy/Seizures
______Tuberculosis
______Cough
______Asthma
______Passing Out
______Gallstones
______AIDS/HIV Positive
______Shortness of breath
______Ulcers/Heartburn
______Chest Pain
______Easy Bruising
______Hepatitis/Jaundice
______Coughing Blood
______Acute MI
______Heart trouble
______One sided weakness
______Radiation Therapy
______Blood clotting problems
______Other serious illness
______Frequent leg Cramps
______Glaucoma/Vision problems
______Loss of Bladder Control
______Unexplained weight loss

Have you had a problem with substance abuse in the past: ____

Do you have any occupational exposure risks, i.e. sunlight, asbestos, loud noise, toxic chemicals or fumes?____
____

PATIENT NAME:________________________________ Date of Birth:_________________

CURRENT MEDICATION: ☐ see attached list

Name of Medication	Dose	Frequency

ALLERGIES:

List all Medicine Allergies:____

IMMUNIZATION HISTORY (with dates if possible)

Td________________________________ Mumps, Measles, Rubella (MMR)____________________

Pneumonia _________________________ Hepatitis B_______________________________

Influenza____________________________

PAST SURGICAL HISTORY:

(List surgery and what year it was done)

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

LIST ALL OTHER HOSPITALIZATIONS (without surgery) AND DATES:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

FEMALE PATIENTS ONLY:

Date of Last Menstrual Period:_____________________ Date of last Mammogram:____________________

Date of last Pap Smear:___________________________ Do you examine your breasts monthly?_________

Are you immune to German Measles (Rubella)?______ Number of Pregnancies:______________________

Number of live births:___________________________ Age at First Menstrual Period:________________

Age at first Pregnancy:_________________________

Do you have a history of the following? Abnormal Pap Vaginal Discharge Irregular Menses Fibroids Endometriosis

Form of Contraception:____

MALE PATIENTS ONLY:

How many times per night do you get up to urinate?

Do you have any of the following?

_______Prostate Trouble ______Decreased Urinary Stream

Last prostate exam:____________________________ Self testicle exams?___________________________

LEARNING ASSESSMENT:

Primary Language:___________English _____________Spanish:____________ Other:_______________

Level of Education:____________________________________

CULTURAL/RELIGIOUS ASSESSMENT:

Do you have any religious or cultural health beliefs that are important for us to know? If you do, please describe:

____

____

ABUSE ASSESSMENT:

Are you currently being physically, sexually, or mentally abused? If so, please describe:___________________

____

DO YOU HAVE A LIVING WILL?______________

Physician Signature:_________________________________(Samuel L.Dandar, MD)

Review Dates:						
Initials:						