

## **MEDICAL HISTORY**

**PLEASE PRINT. PLEASE DO NOT MAIL.**

For your personal privacy,  
please close this form once it is completed.

Chart No: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S D W  
Last Name First Name M

FAMILY DOCTOR: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_  
Name

Address: \_\_\_\_\_  
Street City State Zip

Date of Last Visit: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Tests Performed (please list): \_\_\_\_\_

### PAST SURGICAL HISTORY:

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### PAST MEDICAL HISTORY: Please check No or Yes for each of the following.

<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Pneumonia	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat/Pacer	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Blood Diseases
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> <input type="checkbox"/> Radiation/Chemo
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Memory Loss
<input type="checkbox"/> <input type="checkbox"/> Bronchitis	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Diverticulosis	<input type="checkbox"/> <input type="checkbox"/> Alzheimer's
<input type="checkbox"/> <input type="checkbox"/> Carotid Artery Disease	<input type="checkbox"/> <input type="checkbox"/> Claustrophobia	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> <input type="checkbox"/> Phlebitis	<input type="checkbox"/> <input type="checkbox"/> Seizures
			<input type="checkbox"/> <input type="checkbox"/> MRSA
			Other _____

### HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH THE FOLLOWING?

<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>
<input type="checkbox"/> <input type="checkbox"/> Creutzfeldt-Jakob Disease	<input type="checkbox"/> <input type="checkbox"/> Fatal Familial Insomnia
<input type="checkbox"/> <input type="checkbox"/> Gerstmann-Straussler-Scheinker Disease	<input type="checkbox"/> <input type="checkbox"/> Have you ever received injections of hormones to increase your height?

### HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>	<b>No</b> <b>Yes</b>
<input type="checkbox"/> <input type="checkbox"/> Eye Surgery _____	<input type="checkbox"/> <input type="checkbox"/> Stomach/Abdomen _____	<input type="checkbox"/> <input type="checkbox"/> Cancer _____
<input type="checkbox"/> <input type="checkbox"/> Thyroid/Neck _____	<input type="checkbox"/> <input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> <input type="checkbox"/> Prostate _____
<input type="checkbox"/> <input type="checkbox"/> Heart _____	<input type="checkbox"/> <input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> <input type="checkbox"/> Hysterectomy _____
<input type="checkbox"/> <input type="checkbox"/> Lungs _____	<input type="checkbox"/> <input type="checkbox"/> Hernia _____	Other _____
<input type="checkbox"/> <input type="checkbox"/> Mastectomy _____	<input type="checkbox"/> <input type="checkbox"/> Back _____	Other _____

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Patient: \_\_\_\_\_  
Last Name First Name M

**PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:**

Please list name, dose and frequency. \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:**     No Known Allergies    Latex Sensitivity:     No     Yes

Please list: \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY:**

	Living?		Medical Problems or Cause of Death
	No	Yes	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SOCIAL HISTORY:** Do (Did) you:

No	Yes	Former		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	How much per day? _____ For how many years? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol	How much per day? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drug Use	How much per day? _____

**REVIEW OF SYSTEMS:** Do you have these now? If yes, circle condition and explain.

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin:</b> Psoriasis/Rash/Shingles _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Head:</b> Headache/Migraines/Temporal Arteritis _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes:</b> Cataract/Glaucoma/Retina _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Ears:</b> Hearing Loss/Aids _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Nose/Mouth/Throat:</b> Dentures/Sinus _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Neck:</b> Restriction of Movement/Difficulty swallowing _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Pulmonary:</b> Cough/Shortness of Breath/Wheeze _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>CV:</b> Chest Pain/Palpitations _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>GI:</b> Ulcers/Pain _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>MS:</b> Leg Cramps/Swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Neuro:</b> Tremor/Speech Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Psych:</b> Anxiety/Depression/Insomnia/Panic Attacks _____

**I authorize Reflections at St. Luke's to discuss my medical treatment (all dates)**

**with** \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature Date

