ST. LUKE'S MEDICAL CLINIC

PATIENT HISTORY & PHYSICAL

DATE: ____________

PATIENT NAME: ________________________________ **DOB:** _________________

FAMILY HISTORY: IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Hay fever	11) Arthritis	16) Cancer	
2) Migraine	7) Asthma	12) Heart disease		
3) Glaucoma	8) Anemia	13) Stroke		
4) Diabetes	9) Bleeding disorder	14) Hypertension		
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder		

HOSPITAL	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
ADMISSIONS				
not including				
pregnancies				

LIST ALL MEDICATIONS YOU ARE TAKING			ALLERGIES	VACCINE *YR OF LAST*	VACCINE *YR OF LAST*
				Tetanus/Td	Tdap:
			SUPPLEMENTS	Flu	Tetanus
				Pneumonia	Diptheria
				Hepatitis B	Whooping C
				Hepatitis A	MMR:
				Meningitis	Red Measles
				Chicken Pox	Mumps
					Measles

MEDICAL HISTORY: FROM THE LIST BELOW, PLEASE CIRCLE ANY CURRENT PROBLEMS YOU ARE EXPERIENCING AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASE.

MAIN PROBLEM FOR TODAY'S VISIT: ____

*Hearing problems
*Ringing in ear
*Dizzy spells * Fainting spells
*Vision problems * Eye pain
Date of last eye exam ___________
* Nose bleeds * Sinsus trouble
* Sore throats – *frequent*
* Hoarseness – *prolonged*
* Hayfever / Allergies
* Pneumonia / Pleurisy
* Bronchitis / Chronic cough
* Asthma / Wheezing
Date of last TB test _____________
* Shortness of breath
* on exertion * lying flat
* in the past week
* affects work lifestyle
* Chest pain * High blood pressure
Date of last cholesterol test ______
* Heart mumur *Swollen Ankles
* Irregular pulse * Palpitations
* Leg pain * Cold numb feet
* Varicose veins / Phlebitis
* Appetite * Difficulty swallowing
* loss * gain

* Heartburn * Peptic ulcer
* Aspirin – arthritis – pain pills
* Nausea / vomiting * Gallblader dis
* Jaundice / Hepatitis
* Diarrhea * Constipation
* Diverticulosis * Crohn's / Colitis
* Bloody or tarry stools
* Test for blood in stool
* Hemorrhoids * Hernia
Urination – Overactive bladder
* Overnight > than twice
* More than 8 times / 24 hrs.
* Urgency to urinate * with leakage
* Decrease in force/flow * Painful
* Stress incontinence-urine leakage with exercise / movement
* Blood in urine * Kidney stones
* Urine infections * Prostate prob
* Bed wetting
* Weight-loss * gain
* Anemia * Bruise easily
* Cancer * Fatigue / loss of energy
* Diabetes * Thyroid disease

* Arthritis/Rheumatism * Back pain
* Bone fracture / joint inquiry
* Osteoporosis * Gout
* Rashes * Hives
* Psoriasis * Eczema
* Seizures * Stroke
* Tremor/hands * Numbness
* Headaches * Memory loss
* Depression
* Decreased life enjoyment
* Decreased work performance
* Sleep problems
for how long ____ how often _____
sleeping - * too little * too much
* waking refreshed
* Concentration problems
* Thoughts of – death * suicide
* Anxiety * Mood swings * Phobias
* Vague aches and pains
* Mental illness
* Sexual problems/ enjoyment
* Rheumatic fever * Measles
* Chicken pox * Polio * Mumps

* Tuberculosis * German measles
* Herpes * Aids / HIV * STD
* Alcohol ____________ oz. per week
* Coffee / Tea ________ cups per day
* Smoking – cig/day _______ # years
year quit __________
* Hair loss: * Progressive * Recent
* Exercise _______________________
* Street Drugs ___________________

FEMALES – ***Please complete***
Menstrual flow:
* Reg. * Irreg. * Pain / Cramps
Days of flow ___ Length of cycle ____
Date – 1st day of last period _________
* Pain / Bleeding during or after sex
Number of:
Pregnancies _____ Abortions_____
Miscarriages ____ Live births ____
Birth control method
* Flushing / Menopause
Date of last PAP test ______________
* Normal * Abnormal
Date of last mammogram
* Normal * Abnormal