St. Luke's Medical Group

Date ___________________

Name ____ DOB _________________________

ADULT (18years +) Medical History (circle all that apply)

AIDS/ HIV	Cataracts	Heart Disease	Hyperthyroid	Parathyroid Disease
Alcoholism	Chicken Pox	Heart Murmur	Hypothyroid	Polycystic Ovary
Anemia	Diabetes	Hepatitis	Kidney Disease	Pre Diabetes
Bleeding Disorder	Diabetic Retinopathy	High Cholesterol	Liver Disease	Pneumonia
Calcium Disorder	Glaucoma	High Blood Pressure	Osteoporosis	Stroke
Cancer	Heart Attack	Hypoglycemia	Pacemaker/ AICD	Thyroid Cancer

Other ____

FAMILY HISTORY (circle all that apply)

Arthritis	Diabetes	High Blood Pressure	Kidney Disease	Stroke
Cancer	Heart Disease	High Cholesterol	Liver Disease	Thyroid Disease

Other ____

ALLERGIES (List all medication allergies)

____

SURGERIES ____

HOSPITALIZATIONS ____

SOCIAL HISTORY

Marital Status:____ Occupation ____

Do/have you consume alcoholic beverages (#drinks per week) _________________________ _Quit (date)__________________

Do you/have you smoke(d) (how much per day) _______________________________   Quit (date) _____________________

Other tobacco products (how much per day) ____________________________________Quit (date) ______________________

Recreational drug use (type and frequency) ___________________________________ Quit (date)________________________