Saint Luke's
HEALTH SYSTEM

Patient Name ________________________________

Referring Doctor: ____________________________ Primary Care Physician's Name: ______________________________

MEDICAL HISTORY (CHECK ONLY THOSE THAT APPLY)

Have you had or been diagnosed with any of the following

___Esophageal Reflux
___Esophageal Stricture (narrowing)
___Esophageal Varices
___Gastritis
___Helicobacter Pylori infection
___Stomach Ulcer

___Duodenal Ulcer
___Colon Polyps
___Colon Cancer
___Crohn's Disease
___Ulcerative Colitis
___Irritable Bowel Syndrome

___Diverticulosis
___Diverticulitis
___Chronic Diarrhea
___Chronic Constipation
___Gallstones
___Pancreatitis

___Pancreatic Caner
___Jaundice
___Cirrhosis of Liver
___Hepatitis A
___Hepatitis B
___Hepatitis C

___High Blood Pressure
___Heart Murmur
___Heart Disease
___High Cholesterol
___Artificial Heart Valve

___Anemia
___Diabetes
___Thyroid Disease
___Emphysema/COPD
___Asthma

___Breast Cancer
___Ovarian Cancer
___Uterine Cancer
___Cervical Cancer
___Esophageal Cancer

___Blood Transfusion
___Blood Disorder
___ _____________
___ _____________
___ _____________

Please List All Other Medical Problems You Have Had In The Past:
1. ________________________ 2. ________________________________ 3. __________________________

SURGICAL HISTORY (CHECK ALL THAT APPLY)

	Year		Year		Year
Appendix	_______	Tonsillectomy	______ _	Joint Replacement	_______
Gallbladder Removal	_______	Tubal Ligation	_______	Knee Replacement R/L	_______
Partial Removal of Stomach	_______	Hysterectomy	_______	Knee Surgery R/L	_______
Colon Resection	_______	Heart Bypass	_______	Back Surgery	_______
Hernia Repair	_______	Vascular Surgery	_______	Mastectomy R/L	_______

Other Surgeries: ____

FAMILY HISTORY (PLEASE LIST DISEASES THAT RUN IN YOUR FAMILY AND INCLUDE RELATIONSHIP & MOTHER/FATHER SIDE)

	Relationship		Relationship		Relationship
Colon Polyps	____________	Ulcerative Colitis	____________	Gallbladder Disease	____________
Colon Cancer	____________	Pancreatitis	____________	Stomach Ulcer	____________
Crohn's Disease	____________	Liver Disease	____________	Duodenal Ulcer	____________
Irritable Bowel Synd.	____________	Hepatitis A, B, C, D	____________	Diabetes	____________

Other Diseases: ____

SOCIAL HISTORY

Are You ____ Single ____ Married ______ Divorced ____ Widowed Number of Children ______

What is your current occupation? ____

Y N	Do you Smoke/chew? If no, please list either you are a never smoker or former smoker.			__________
Y N	Do you drink alcohol?		If yes, how much per week?	__________
Y N	Have you ever used intravenous drug or other street drugs?		If yes, what type and last used?	__________
Y N	Have you ever had a body piercing?		If yes, was a clean technique used?	__________
Y N	Have you ever had a tattoo?		If yes, was a clean technique used?	__________

Please tell us briefly on why we are seeing you today: ____

____

REVIEW OF SYSTEMS **(Add a check mark next to any symptoms that you are currently experiencing)**

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Difficulty Swallowing
- ☐ Food Sticks with swallowing
- ☐ Frequent Heartburn
- ☐ Poor Appetite
- ☐ Excessive Gas/Bloating
- ☐ Abdominal Pain
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Dark Tarry Stools
- ☐ Jaundice

GENERAL

- ☐ Chronic Fatigue
- ☐ Weight Loss
- ☐ Fever
- ☐ Bruise Easily
- ☐ Bleed Easily
- ☐ Anemia

EARS, EYES, NOSE & THROAT

- ☐ Ear Infections
- ☐ Poor Vision
- ☐ Wear Eye Glasses
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Fever Blisters
- ☐ Hoarseness

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Rate
- ☐ Atrial Fibrillation

URINARY

- ☐ Urinary Infections
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Stones

NEUROLGICAL/PSYCHIATRIC (Past or Present)

- ☐ Stroke
- ☐ Tremors
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Panic Attacks
- ☐ Depression
- ☐ Anxiety

BONES AND JOINTS

- ☐ Arthritis
- ☐ Gout
- ☐ Back Pain
- ☐ Osteoporosis

SKIN

- ☐ Hives
- ☐ Rash
- ☐ Allergic Reactions
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dermatitis

RESPIRATORY

- ☐ Asthma
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Bronchitis