St. Luke's MEDICAL GROUP
Primary Care of Imperial

DATE: _____

Adult Medical Questionnaire

NAME (Last, First, Middle): _____
Birth Date: ____/____/_____ **AGE:** _____ **Sex: M F Gender Preference:** _____
Marital Status: _____ **Name of Spouse:** _____
Your Occupation: _____
Children Names and Ages: _____

Medical History: Please list any medical problems you have, take medications for, or have had in the past.

_____

_____

When was your last: Colonoscopy_____Blood Work_____
(Men) PSA_____
(Women) Pap Smear_____ Mammogram _____
Bone Density_____# of Pregnancies_____
Last Period_____

MEDICAL PROVIDERS or Specialists:

Name	**Specialty**	**Telephone Number**

CURRENT MEDICATIONS:

Medication Name	Dosage (MG)	# of times per day	Medication Name	Dosage (MG)	# of times per day

SURGICAL HISTORY:

Type of Surgery	Date	Type of Surgery	Date

HOSPITIZATIONS:

Reason for hospitalization	Date	Reason for hospitalization	Date

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Adult Medical Questionnaire

ALLERGIES: Please list any drug, food or contact allergies.

_____

_____

SOCIAL HISTORY:

( ) Tobacco: # of packs/day____ #years ____ ( ) Vaping: YES or NO

( ) Alcohol: #drinks/day____ ( ) Caffeine: #drinks/day____

How often do you exercise?_____ What type of exercise do you get?_____

Do you eat a balanced diet? Yes / No

Are you currently or have you ever used intravenous or recreational drugs? Yes / No

If yes, please list: _____

FAMILY HISTORY:

Mother: Age ____ Living ( ) Medical Problems:_____

Deceased ( ) Cause of Death:_____

Father: Age ____ Living ( ) Medical Problems:_____

Deceased ( ) Cause of Death:_____

Please check where you or members of your family have had the following (Parent, siblings, children, grandparents).

	Allergies		**Diabetes**		**High Blood Pressure**		**Seizures**
	Anemia		**Glaucoma**		**High Cholesterol**		**Other inherited diseases**
	Cancer		**Heart Problems**		**Kidney Problems**		

REVIEW of SYSTEMS: Please check any symptoms below you feel are affecting your health.

	Skin Problems		**Cough**		**Hemorrhoids**		**MEN:**
	Headaches		**Shortness of Breath**		**Burning with Urination**		**Poor Urine Stream**
	Head Injuries		**Chest Pain**		**Blood in Urine**		**Prostate Problems**
	Loss of Consciousness		**Heart Attack**		**Joint/Bone Pain**		**Burning Discharge**
	Visual Problems		**Palpitations**		**Back Pain**		**Erection Problems**
	Sinus Problems		**Swelling of legs/feet**		**Weakness**		
	Nose Bleeds		**Abdominal Pain**		**Seizures**		**WOMEN:**
	Seasonal Allergies		**Nausea/Vomiting**		**Sleeping Problems**		**Irregular or Heavy Periods**
	Hearing Problems		**Diarrhea**		**Nervousness/Anxiety**		**Vaginal Discharge**
	Neck Lumps		**Constipation**		**Depression**		
	Thyroid Problems		**Change in Bowels**		**Weight Gain**		
	Difficulty Swallowing		**Black/Tarry Stools**		**Weight Loss**		

Are you concerned that you have or that you might get any diseases? Yes / No

Information on both pages will be entered into EHR and paper document shredded.

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St. Luke's MEDICAL GROUP

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NEW PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: _____ How did you hear about us?:_____

Name: (Last, First, Middle)_____

Name you prefer to go by:_____ Birth/Maiden Name:_____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ Declined ☐ Amer. Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other

Ethnic Group: ☐ Declined ☐ American ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Language: ☐ English ☐ Other

Address: _____ City:_____

State: _____ Zip: _____ Home Phone: _____ Work: _____

Cell Phone: _____ Email Address: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message

Employer Name: _____

RESPONSIBLE PARTY INFORMATION – Note if you are over the age of 18 yrs. You are responsible for yourself.

Name of Responsible Person: _____ Date of Birth:_____

Relationship to patient: ☐ Self ☐ Child ☐ Spouse ☐ Other

Address: _____ City:_____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Employer Name and Address: _____ Occupation: _____

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Continuation: PATIENT INFORMATION

EMERGENCY CONTACT INFORMATION

Emergency Contact Name**:** _____ Relationship to patient: _____

Emergency Contact DOB:_____

Home: _____ Cell: _____ Work: _____

(PRIMARY) INSURANCE INFORMATION

Name of Insurance: _____ ID #_____ Group #_____

Primary Policy Holder Subscriber:_____

Subscribers Date of Birth: _____

Relationship to the Patient: _____

(SECONDARY) INSURANCE INFORMATION

Name of Insurance: _____ ID #_____ Group #_____

Name of Primary Policy Holder:_____ Date of Birth: _____

Relationship to the Patient: _____

_____ _____

Signature Date

_____ _____

Parent (if minor) Date

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