LUTHER FAMILY CARE

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly we need the following information. All information will remain confidential. Please print.

Patient's Legal Name: (Last)_____(First)_____

SSN:_____ Birthdate:_____

Adress:_____

City:_____ State:_____ Zip:_____

Phone Number (the number we can reach you for test results, appts, etc):_____

Email Address:_____

Please circle appropriate answers

Sex: Male Female Marital Status: Single Married Divorced Widowed

Race: Caucasian African American American Indian Hispanic Other:_____

Primary Care Physician: _____

Emergency Contact Name: _____ Relationship:_____

Phone Number:_____

Insurance Information:

Guarantor Information: (if guarantor is patient, omit this section)
Name:_____ Address:_____
Phone Number:_____ SSN:_____
Relationship to Patient:_____
Primary Insurance:_____ ID:_____
Group # _____
Secondary Insurance: _____ ID #_____
Group #_____
By my signature below I affirm that I have been provided with copies of HIPPA, Patient Bill of Right and I consent to treatment at The Luther Clinic

_____
Patient's Signature (or legal guardian) Date

FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE

ALLERGIES

List anything that you are allergies to (medications, food, bee stings, etc) and how each affects you.

Allergy	Reaction

FAVORITE PHARMACY AND ZIP CODE:_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs. Please include vitamins etc.

DRUG NAME	STRENGTH	FREQUENCY TAKEN

IMMUNIZATION HISTORY

VACCINE	DATE OF IMMUNIZATION
Tetanus	
Flu	
Shingles	
Pneumonia	

☐ Anxiety	☐ Fibromyalgia	☐ Depression	☐ Stroke
☐ Arthritis	☐ Gout	☐ Hepatitis A B C	☐ Tuberculois
☐ Asthma	☐ Pacemaker	☐ Seizure	☐ Other
☐ Bleeding Disorder	☐ Heart Attack	☐ Kidney Disease	☐
☐ Blood Clots	☐ Heart Murmur	☐ Kidney Stones	☐
☐ Cancer	☐ HIV or AIDS	☐ Leg/ Foot Ulcers	☐
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Obstructive Sleep Apnea	☐
☐ Diabetes- Insulin	☐ High Cholesterol	☐ Liver Disease	☐
☐ Diabetes- Noninsulin	☐ High Blood Pressure	☐ Osteoporosis	☐
☐ Dialysis	☐ Thyroid disorder	☐ Pulmonary Embolism	☐
☐ Diverticulitis	☐ Heart Disease	☐ Stomach Ulcer	☐

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			
5.			

SOCIAL HISTORY:

Please circle

Education: < 8th grade High School 2 Year College 4 Year College Post Graduate

Exercise: No Exercise Occasional Exercise Moderate Exercise High level Exercise

Caffeine: None Occasional Moderate Heavy # of cups per day _____

Alcohol: Never Occasional < 3 times/week >3 times per week ____ # of drinks/ week

Have you ever been treated for alcoholism? Yes NO

Tobacco use:

Do you use tobacco? YES NO

If not now, did you ever use tobacco? YES NO

Cigarettes # of packs/day_____

Chew # of cans/day_____

Cigars # of cigars/day_____

# of Years of tobacco use?_____

Year Quit_____

Drugs:

Do you currently use recreational or street drugs? YES NO

If yes then please list:

_____

_____

Have you ever been treated for drug use? When?

_____

FAMILY HEALTH HISTORY

Relation	Alive?	High Chole-sterol	Hyper-tension	Heart Disease	Stroke	Diabetes	Cancer	Osteoporosis	Depression	Alcoholism		
Grandfather (Maternal)												
Grandmother (maternal)												
Grandfather (paternal)												
Grandmother (paternal)												
Father												
Mother												
Brother/Sister												
Brother/Sister												
Other												

WOMEN ONLY- OBSTETRIC AND GYNECOLOGICAL HISTORY

Are you pregnant or breastfeeding?_____

Age of first Menstrual Period?_____ Age of Last Period/ Menopause?_____

Number of Pregnancies:____ Number of Miscarriages:____ # of Births____ # of living children_____

Current Sexual Partner is ☐ Male ☐ Female

Birth control method used?_____

PREVENTATIVE HEALTHCARE QUESTIONAIRE

WOMEN ONLY

Last Papsmear_____ Abnormal/ Normal
Last Mammogram_____ Abnormal/Normal
Have you ever had a bone density test, if so when? Results?_____

MEN ONLY

If 65-75 years old, have you ever had an abdominal aortic ultrasound, if so when? Results?_____

MEN AND WOMEN

Last annual labwork?_____
If born between 1945-1965 , have you ever been screened for hepatitis C?_____
If 55-74 years old who smoke, ever been screened for Lung Cancer by Chest CT?_____
Last Colonoscopy_____ Normal/Abnormal?_____

Do you see an eye doctor regularly? When was your last vist?_____
Do you see a dentist Regularly, When was your last visit?_____

ADDITIONAL HEALTH FACTS: Please add other information you would like the provider to know.

_____
_____

_____

PATIENT SIGNATURE **DATE**