Lutheran Health Physicians
Kosciusko Medical Group

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________ Date of Birth: ________________________

Telephone: Home:________________ Cell:________________Work: ______________

Emergency Contact: ________________ Relationship:__________Telephone:__________

CURRENT MEDICATIONS: ☐ None

Please list ANY medications you are currently taking, including over-the counter medications and vitamins.

Drug Name	Dosage	Frequency

MEDICATION ALLERGIES: ☐ None

DRUG NAME	DESCRIBE REACTION

PAST MEDICAL HISTORY: ☐ None

Please check all that apply and indicate date/year of onset

DISEASE	***YEAR of ONSET***	***DISEASE***	***YEAR of ONSET***	***DISEASE***	***YEAR of ONSET***
☐ High Blood Pressure	________	☐ Thyroid Disease	________	☐ Arthritis	________
☐ Heart Murmur	________	☐ Diabetes	________	☐ Anemia	________
☐ High Cholesterol	________	☐ Kidney Disease	________	☐ Headache	________
☐ Heart Attack	________	☐ Bronchitis	________	☐ Menstrual Disorders	________
☐ Congestive Heart Failure	________	☐ Pneumonia	________	☐ Venereal Disease	________
☐ Stroke	________	☐ COPD	________	☐ Other	________
☐ Rheumatic Fever	________	☐ Tuberculosis	________	☐ Other	________
☐ Hemorrhoids	________	☐ Asthma	________	☐ Other	________
☐ Ulcers	________	☐ Allergies/Hayfever	________	☐ Other	________
☐ Intestinal Disorders	________	☐ Depression	________		
☐ Pancreatitis	________	☐ Anxiety	________	Pregnancies	
☐ Diverticulitis	________	☐ Cancer	________	☐ Vaginal	________
☐ Liver Disease	________	Specify Cancer	________	☐ Cesarean	________
☐ Hepatitis	________				

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PAST SURGICAL HISTORY: ☐ None

☐ Gall Bladder ______	☐ Appendix______	☐ Hysterectomy______	☐ Ovaries______
☐ Tubal Lig/Vasectomy______	☐ Sinus______	☐ Tonsils/Adenoids______	☐ Tubes/Ears______
☐ Prostate ______	☐ Hernia______	☐ Breast______	☐ Colon______
☐ Back ______	☐ Knee______	☐ Hip______	☐ Cataracts______
☐ Heart______	☐ ______	☐ ______	

PREVENTIVE MEDICINE: ☐ None

(Please indicate the month and year the following tests were performed)

Mammogram ______	Colonoscopy______	Flu Shot______ ______
Dexa______ ______	PSA______	Pneumonia Shot______
Pap/Pelvic Exam ______	Stress Test______	Shingles Vaccine______
Cholesterol ______	EKG______	Tetanus______

SOCIAL HISTORY: ☐ Married ☐ Single ☐ Divorced Lives with ______ OR Lives Alone

Occupation ______

Smoking	☐No	☐Yes	_____ Pack per day for _____ years	☐ Prior Use
Alcoholic Beverage	☐No	☐Yes	_____ Drinks or Beers per Week	☐ Prior Use
Drugs	☐No	☐Yes	Type: ______	☐ Prior Use
Caffeine (Coffee or Pop)	☐No	☐Yes	_____ Cups/Cans per day	

FAMILY HISTORY: Please indicate illnesses listed above for each family member including age at start of heart disease and type of cancer. If family member deceased, please indicate age and cause of death.

FATHER:	
MOTHER:	
BROTHER 1:	
BROTHER 2:	
SISTER 1:	
SISTER 2:	
OTHER:	
OTHER:	

Additional information you would like to share with your physician:

______
______
______
______

______ Patient Signature ______ Date

______ **PHYSICIAN SIGNATURE** ______ **Date**