Saint Luke's Health System
saintlukeshealthsystem.org

Name: ____ Date of Birth: _________________________

Family History – Especially heart disease, stroke, diabetes, high cholesterol, high blood pressure, murmur. Please include the cause of death if applicable.

Father: _______________________________________

Mother: ______________________________________

Sister(s):______________________________________

____

Brother(s): ____________________________________

____

Single_____ Married_____ Widowed_____ Divorced ______

Do you have children? If yes, how many and ages?

____

____

Please check Yes or No for the current or ongoing symptoms below:

Yes	No			Yes	No			Yes	No	
		Fever				New Fainting				Abnormally Great Thirst
		Fatigue				Difficulty Breathing While Lying Flat				Bleed/Bruise Easily
		Night Sweats				Palpitations				Brief Paralysis
		Nosebleeds				Awaken Gasping for Air				Coordination Disturbances
		Difficulty Swallowing				Loss of Consciousness				Daytime Sleepiness
		Black or Blood Stools				Blood in Urine				Dizziness
		Nausea				Cough				Focal Weakness
		Vomiting				Blood in Sputum				Light-Headedness
		Chest Pain				Shortness of Breath				Loss of Balance
		Cramping Pain in Leg(s) When Walking				Sleep Disturbances due to Breathing				Numbness
		Bluish Discoloration of Skin Due to Poor Circulation or Low Oxygen Levels				Snoring				Tingling or "Pins and Needles" Sensation
		Shortness of Breath with Exertion				Wheezing				Rash
		Irregular Heartbeats				Intolerance of Cold				Joint Pain
		Leg Swelling								Muscle Pain

Do you consume caffeine? Y/N How often________ Amount ________ Type ________

Do you use tobacco? Y/N Do you use smokeless tobacco Y/N Do you use drugs? Y/N

Do you use alcohol? Y/N How many drinks per week? ________________

Name: ____ Date of Birth: _________________________

Diet: _____ Regular _____Low Carb _____Low Salt _____Diabetic _____No Added Salt _____Weight Loss

_____ Low fat/Calorie _____Vegetarian _____Vegan

Do you exercise? If yes, exercise type and frequency: ____

Are you taking medications? Yes _____ No _____ If yes, please let your current medications below:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

What pharmacy do you prefer?

Local Pharmacy Name: ____ Phone Number: ___________________

Address: ____

Street State Zip Code

Mail-Order Pharmacy Name: ____ Phone Number: ____________________

Do you have any drug allergies/intolerances? (Please circle one) No Known Drug Allergies Yes

If **YES**, please list the drug allergy/intolerance and the type of reaction: ____

____

Please list all procedures/surgeries including dates/locations if possible (include heart catheterization, angioplasty/stents, bypass surgery, peripheral vascular study, and electrophysiology study): _________________________

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Vital Signs

PLEASE DO NOT WRITE BELOW THIS LINE

Blood pressure: Right: _______________ (Sitting) Left: __________________ (Sitting) Pulse: __________ (Sitting)

Height: ___________ Weight: ___________ Waist Circumference: ___________