St. Luke's MEDICAL GROUP | Primary Care of Eureka
Family Medicine
Heather Gjorgjievski, DO

New Patient Medical History – Please complete both pages

Name: _____ Date of Birth: ____/____/____ Age: _____Sex:_____

How did you hear about our practice?

Please briefly state in the box below the reason for your visit:

Allergies or Intolerances

List below medication or foods causing an allergic reaction and what reaction you get from it (hives, nausea, etc.)

Medication/Food	Reaction	Medication/Food	Reaction

Medications, Vitamin and Herbal Supplements

Medication	Strength	# of pills taken and frequency	Medication	Strength	# of pills taken and frequency
Example: Tylenol	500mg	1-twice daily			

Past Medical History

Condition/Disease	Year Began	Condition/Disease Other(s)	Year Began
☐ Hypertension			
☐ High Cholesterol			
☐ Hypothyroidism (low thyroid)			
☐ COPD, Emphysema or Asthma			
☐ Diabetes			
☐ GERD			
☐ Depression or Anxiety			
☐ Heart Problems			

Disease Prevention and Health Maintenance

Please list below the most recent dates for the following vaccines/tests:

	Month/Yr		Month/Yr		Month/Yr
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Cholesterol Check	
Gardasil Vaccine		Chest X-ray		HIV Test	

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

Family Health History

Please list below the health history your blood (genetics) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

Social, Educational and Work History

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed / Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:		
What type of exercises do you do, duration & frequency?		
Do you drink alcohol?	What type?	# of drinks per week?
Are you a current smoker? Y / N	If you smoke, how many packs per day?	
Are you a former smoker? Y / N	Year quit	# of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Y / N	Male / Female / Both	Total partner(s) in last 12 months
List any drugs you use or have used		

Review of Systems

Review the following symptoms and circle those items that are a problem for you: If non apply circle this X

Fever	Weight loss / gain	Fatigue	Night sweats	Weakness
Vision problems	Anxiety	Depression	Trouble Sleeping	Bipolar Disorder
Hearing problems	Sinus trouble	Trouble swallowing	Nosebleeds	Hoarseness
Chest pain	High blood pressure	High cholesterol	Palpitations	Dizziness
Shortness of breath	Wheezing	Asthma/COPD	Cough	Coughing blood
Nausea/Vomiting	Diarrhea/Constipation	Acid Reflux	Blood in stool	Abdominal pain
Frequent Urination	Incontinence	Blood in urine	Enlarged prostate	Frequent urination at night
Irregular periods	Heavy menses	Abnormal pap	Breast discharge	Lump in breast
Joint pain / stiffness	Chronic back pain	Arthritis	Lupus	Carpal tunnel
Rash	Eczema	Concerning moles	Psoriasis	Rosacea
Headaches	Seizures	Numbness / tingling	Fainting	Tremor
Anemia	Easy bruising	Blood clot	Swollen lymph nodes	History of STDs
Heat/cold intolerance	Excessive hunger	Excessive thirst	Thyroid disease	High blood sugar
Hay fever	Itchy watery eyes	Eczema	Runny nose	Suicide attempts