St. Luke's
MEDICAL GROUP

Dear Patient,

Thank you for choosing St. Luke's Medical Group for your care. Our practice team looks forward to supporting you on your health journey.

As members of St. Luke's Medical Group, we are dedicated to providing you with exceptional care. We respect your individuality, listen to your concerns, and provide you with high quality, safe care.

We use *my*stlukes patient portal to communicate with patients. With *my*stlukes, you can send us private and secure messages, request appointments and access your health information, including test results and office visit summaries.

If you already have a *my*stlukes patient portal account, you should have received an email notifying you that you have a clipboard in your portal with new patient paperwork to fill out. Please log in and fill it out before your appointment. This will help make your first visit with us as smooth and efficient as possible.

If you didn't have a *my*stlukes patient portal account when we set up your appointment, we sent you an email with instructions to get started. Please finish setting up your account and fill out the new patient paperwork on your clipboard.

You can also complete the new patient paperwork posted on your doctor's profile on St. Luke's website, stlukes-stl.com. Please send your paperwork to the office before your appointment or bring it with you.

Please arrive 15 minutes before your appointment to allow time for registration. Don't forget to bring your insurance card and photo ID, as well as a list of any medications and supplements you are taking.

Again, thank you for choosing us for your health care. It is a privilege to serve you.

Sincerely,

Tammy Lett, RN, MBHA
Senior Vice President Physician Network
St. Luke's Medical Group

St. Luke's Medical Group
Patient Registration Form **Name:** _____ **DOB:** _____

Primary Care Physician _____

Patient Legal Name

Last Name _____ First Name _____

Middle Name _____ Suffix _____

Previous Last Name _____ Preferred Name _____

Pronouns _____
(He/Him/His, She/Her/Hers, They/Them/Theirs, No Pronouns, Other)

Demographics

Sex (M/F/Nonbinary/Unknown) _____ Birth Sex (M/F/Nonbinary/Unknown) _____ DOB _____

Preferred Language _____ Race _____ Ethnicity _____

Marital Status _____ Employer _____ Occupation _____
(Married, Divorced, Single, Other)

Home Mailing Address

Street Address _____ Apartment # _____

City _____ State _____ Zip Code _____ Country _____

Contact Information

Home Phone _____ Mobile Phone* _____ Work Phone/Extension _____ _____
(*Mobile Phone will be listed as your preferred phone unless indicated otherwise.)

Email Address (Required for mystlukes Patient Portal) _____
(Your challenge question for patient portal registration will be your 5-digit zip code.)

Appointment Reminders: Appointment reminders will be sent by Text Message to your Mobile Phone Number.

Emergency Contact

Emergency Contact Name (Last, First, Middle Initial) _____

Emergency Contact Date of Birth: _____ Patient's Relationship to Emergency Contact: _____
(Child, Spouse, Parent, etc.)

Emergency Contact Home Phone _____ Mobile Phone _____ Work Phone _____

St. Luke's Medical Group
Health History Form **Name:** _____ **DOB:** _____

Reason for visit today:

_____

_____

Preferred Lab:	**Preferred Pharmacy:**
[ ] St. Luke's Lab	[ ] St. Luke's Pharmacy
[ ] LabCorp	[ ] Other Pharmacy: _____ Phone: _____ Pharmacy address: _____
[ ] Quest	[ ] Mail order pharmacy: _____ Phone: _____ Pharmacy address: _____

Medical Problems and Visit Diagnosis (Place a checkmark by all that apply and add any conditions not listed.)

[ ] Acid Reflux/Heartburn	[ ] Depression	[ ] Thyroid disease (hyper or hypo) _____
[ ] ADHD/ADD	[ ] Diabetes	**Other conditions not listed:**
[ ] Alcohol Abuse	[ ] Drug Dependency	[ ] _____
[ ] Anemia	[ ] Fatty Liver Disease	[ ] _____
[ ] Anxiety	[ ] Heart Attack (date:_____)	[ ] _____
[ ] Asthma	[ ] High Blood Pressure	[ ] _____
[ ] Atrial Fibrillation	[ ] High Cholesterol	[ ] _____
[ ] Cancer (type: _____)	[ ] Irritable Bowel Syndrome	[ ] _____
[ ] Chronic Kidney Disease	[ ] Migraines	[ ] _____
[ ] Congestive Heart Failure	[ ] Osteoporosis/Osteopenia	[ ] _____
[ ] COPD/Emphysema	[ ] Prostate problems	[ ] _____
[ ] DVT/Pulmonary Embolism	[ ] Sleep Apnea	[ ] _____
[ ] Dementia	[ ] Stroke (date: _____)	[ ] _____

Surgical History (surgeries, procedures, hospitalizations)

Please list all past hospitalizations, procedures, and surgeries with approximate dates

	Hospitalizations, Procedures, Surgeries:	**Date:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medications (Please list all of your prescribed and over-the-counter medications.)

	Medication:	**Dose:**	**Frequency:**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Allergies

Please list any **allergies** to medications and/or foods and the types of reactions for each.

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Foods: _____ Reaction: _____

Foods: _____ Reaction: _____

Foods: _____ Reaction: _____

Social History: Tobacco Use

Smoking Tobacco Use:

[ ] Current every day smoker
[ ] Current some day smoker
[ ] Former smoker
[ ] Heavy tobacco smoker
[ ] Light tobacco smoker
[ ] Never smoker
[ ] Smoker, current status unknown
[ ] Not obtained due to cognitive impairment

Number of packs per day: _____ Age started: _____ Age quit: _____

Smokeless Tobacco Use:

[ ] Never
[ ] Vape / e-cigarette / smokeless tobacco (within the past 30 days)
[ ] Former smokeless tobacco user, quit more than 30 days ago
[ ] Not obtained due to cognitive impairment

Tobacco Cessation Counseling Requested: [ ] Yes [ ] No [ ] N/A

Type of Tobacco:

[ ] Cigarettes
[ ] Cigars
[ ] Oral
[ ] Pipe
[ ] Electronic Cigarettes
[ ] Other: _____

Alcohol Use

Alcohol Use:
[ ] Current every day alcohol user
[ ] Current some day alcohol user
[ ] Former alcohol user
[ ] Never alcohol user
[ ] Current status unknown
[ ] Unknown if ever used alcohol

Type: [ ] Beer [ ] Wine [ ] Liquor [ ] Other: _____

Frequency:
[ ] 1-2 times per year
[ ] 1-2 times per month
[ ] 1-2 times pr week
[ ] 3-5 times per week
[ ] Daily
[ ] Several times per day

Date of last Use: _____

Substance Use

Drug Use:
[ ] Current every day drug user
[ ] Current some day drug user
[ ] Former drug user
[ ] Never drug user
[ ] Current status unknown
[ ] Unknown if ever used drugs

Type:
[ ] Amphetamines
[ ] Cocaine
[ ] Ecstasy
[ ] Hallucinogens/LSD
[ ] Heroin
[ ] Inhalants/Glues/Solvents
[ ] Marijuana
[ ] Methamphetamines
[ ] Prescription medications
[ ] Other: _____

Frequency:
[ ] 1-2 times per year
[ ] 1-2 times per month
[ ] 1-2 times pr week
[ ] 3-5 times per week
[ ] Daily
[ ] Several times per day

Date of last Use: _____

Family History

Please list any diseases or medical conditions your family members have currently or have had in the past.

Mother: _____

Father: _____

Sister: _____

Brother: _____

Son: _____

Daughter: _____

Grandparents (Maternal): _____

Grandparents (Paternal): _____

Sexual History

Sexually active/inactive: _____

Contraception: _____

STD/HIV History: _____

Sexual Orientation: _____

OB/GYN History

Number of pregnancies: _____ Number of live births full-term: _____ Number of live births pre-term: _____

Number of abortions: _____ Number of living children: _____

Menstrual Status: [ ] Have menstrual periods [ ] Post-menopausal [ ] Never had a menstrual period

Date of last menstrual period: _____ Date of last PAP: _____ PAP result: _____

Contraception type: _____

Fall Risk

Any history of falling in the last 3 months?	[ ] Yes	[ ] No
Do you ever experience dizziness or vertigo?	[ ] Yes	[ ] No
Do you ever wet or soil yourself on the way to the bathroom?	[ ] Yes	[ ] No

Depression Screen

Over the last two weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer.)	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
Feeling down, depressed or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some say				

Medical Devices/Radiology Testing Precautions

[ ] None
[ ] Unknown
[ ] Aneurysm clips in head or aneurysm coiling
[ ] Aortic grafts
[ ] Breast tissue expander
[ ] Bone growth stimulator
[ ] Cochlear implant
[ ] Coronary artery stent or vascular stent
[ ] Deep brain stimulator
[ ] Implantable cardioverter-defibrillator
[ ] Implanted venous access device
[ ] Insulin pump
[ ] Medication pump
[ ] Neurostimulator
[ ] Pacemaker
[ ] Penile implant
[ ] Prosthetic heart valve
[ ] Sleep apnea implanted device
[ ] Ventricular shunt

Radiology Testing Barriers/Precautions

[ ] None
[ ] Unknown
[ ] GI clips
[ ] Glucose sensor
[ ] Intrauterine device
[ ] Magnetic-based cosmetics (eyelashes, eyeliner, etc.)
[ ] Metal fragments in eyes
[ ] Metal plates, pins, rods, or screws
[ ] Shrapnel or bullets
[ ] Tattoo
[ ] Other: _____

Medical Device Card

[ ] Copied/placed in chart
[ ] Patient planning to bring in a copy
[ ] Unable to obtain
[ ] Other: _____

Advance Directive

[ ] Yes
[ ] No

Type of Advance Directive
[ ] Outside of Hospital DNR
[ ] Living will
[ ] Medical durable power of attorney
[ ] Other: _____

Location of Advance Directive
[ ] Copy placed in patient chart
[ ] Patient planning to bring in a copy
[ ] Unable to obtain copy
[ ] Other: _____

Immunizations

Please provide the last date(s) completed for each of the following, and where received.

Immunization:	Date(s):	Location where received:
Covid		
Flu (Influenza)		
HPV (3 dates)		
Hepatitis A (2 dates)		
Hepatitis B (3 dates)		
Pneumonia [ ] 13 [ ] 23 [ ] 20 [ ] 21		
RSV		
Shingles [ ] Shingrix or [ ] Zostavax		
Tetanus		

Health Maintenance

Please provide the last date completed and facility/location for each of the following.

Test:	Date:	Location where received:
Bone Density		
Cologuard		
Colonoscopy		
Eye Exam		
Mammogram		
PAP		

If Diabetic, last date completed and location for each of the following:

Test:	Date:	Location where received:
HgbA1c		
Urine albumin/creatinine ratio		

Physician Care Team

Please provide the name of your physician for each of the following specialties, if applicable (**First & Last Name please**).

Cardiologist: _____ OB/GYN: _____

Dermatologist: _____ Ophthalmologist: _____

Endocrinologist: _____ Podiatrist: _____

ENT (Ear, Nose, Throat): _____ Psychiatrist/Psychologist: _____

Gastroenterologist: _____ Rheumatologist: _____

Hematologist/Oncologist: _____ Urologist: _____

Neurologist: _____ Other: _____