THE UNIVERSITY OF KANSAS HEALTH SYSTEM
ST. FRANCIS CAMPUS

**The University of Kansas Health System St. Francis Campus**
**1700 SW 7th St.**
**Topeka, KS 66606**

**PATIENT MEDICAL PROFILE**

Patient Name:_____ Date of Birth:_____

## MEDICAL HISTORY

Please select any problems you currently have or have had in the past.

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Blood clots
- ❑ Cancer
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Drug abuse
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Heart disease / attack
- ❑ Heart failure
- ❑ Heartburn / reflux
- ❑ Hepatitis
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Seizure disorders
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid problems
- ❑ **NONE OF THESE APPLY TO ME**

## SURGICAL HISTORY

Please list all previous surgeries and the approximate year: ❑ **I HAVE NOT HAD ANY SURGERIES**

| Surgery: | Year: | Surgery: | Year: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## FAMILY HISTORY

Does anyone in your immediate family (parents, brothers, sisters, children) have any of the following?

- ❑ Ankylosing spondylitis
- ❑ Asthma
- ❑ Blood clots
- ❑ Cancer
- ❑ Diabetes
- ❑ Gout
- ❑ Heart disease
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lupus
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ **NONE OF THESE APPLY TO ME**

## SOCIAL HISTORY

**Hand Dominance:** ❑ Right ❑ Left ❑ Ambidextrous
**How often do you exercise?** ❑ Never ❑ Occasionally ❑ Frequently ❑ Daily
**Tobacco Use:** ❑ Yes ❑ No ❑ Former Year quit: _____
Type: ❑ Chewing ❑ Cigar ❑ Cigarette ❑ Pipe
Number of years used:_____
**Alcohol Use:** ❑ Yes ❑ No ❑ Former Year quit:_____
How often do you drink? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely

## REVIEW OF SYSTEMS

Do you currently have any of these problems?

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | | **Cardiovascular** | | **Skin** | |
| Chills | ❑ Yes ❑ No | Chest pain | ❑ Yes ❑ No | Rash | ❑ Yes ❑ No |
| Fever | ❑ Yes ❑ No | Irregular heartbeat | ❑ Yes ❑ No | Skin infection | ❑ Yes ❑ No |
| **HEENT** | | **Gastrointestinal** | | **Neurologic** | |
| Headache | ❑ Yes ❑ No | Abdominal Pain | ❑ Yes ❑ No | Difficulty walking | ❑ Yes ❑ No |
| Dizziness | ❑ Yes ❑ No | Heartburn | ❑ Yes ❑ No | Seizures | ❑ Yes ❑ No |
| **Respiratory** | | **Genitourinary** | | **Metabolic** | |
| Cough | ❑ Yes ❑ No | Frequent urination | ❑ Yes ❑ No | Cold intolerant | ❑ Yes ❑ No |
| Short of breath | ❑ Yes ❑ No | Blood in urine | ❑ Yes ❑ No | Heat intolerant | ❑ Yes ❑ No |
| **Psychiatric** | | **Hematologic** | | **Immunologic** | |
| Anxiety | ❑ Yes ❑ No | Easy bleeding | ❑ Yes ❑ No | Asthma | ❑ Yes ❑ No |
| Depression | ❑ Yes ❑ No | Easy bruising | ❑ Yes ❑ No | Environment allergy | ❑ Yes ❑ No |

## SIGNATURE

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the doctor of any changes in my medical status.

_____ _____
Signature of Patient (parent or guardian if the patient is a minor) Date

**PATIENT INFORMATION**