St Johns Health Center

Thoracic & Esophageal Surgery

Robert J. McKenna, Jr, MD,FACS

2121 Santa Monica Blvd

Santa Monica, CA 90404

Phone:(310) 829-8618 Fax (310)829-8607

Patient Label

New Patient Health Questionnaire

Registration/Demographic Information

Name: _____ Today's date: _____

Address: _____ Date of Birth: _____

_____ SS#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Driver's License #: _____ State: _____ Gender: ☐ Male ☐ Female

Primary language: ☐ English ☐ Spanish ☐ Farsi ☐ Russian ☐ Other: _____

Interpreter needed: ☐ Yes ☐ No Race: ☐ Caucasian ☐ African-American ☐ Hispanic

☐ Asian/Pacific Islander ☐ Native American/Alaskan ☐ Other: _____

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed ☐ Domestic Partner

Birth Place: _____ Religion: _____

Mother's Maiden Name: _____ Patient's Maiden Name: _____

Insurance Information

Primary: _____ _____ Group#: _____

Type: ☐ Medicare ☐ PPO ☐ HMO

Secondary: _____ ID #: _____ Group#: _____

Type: ☐ Medicare ☐ PPO ☐ HMO

Subscriber's Name (if other than patient): _____ Date of Birth: _____

Employer Information

Employer: _____ Occupation: _____

☐ Full Time ☐ Part time ☐ Self-employed ☐ Never worked ☐ Unemployed ☐ Retired (as of: _____) ☐ Active Military

Title: _____ Work Phone/extension: _____

Street: _____ City: _____ State: _____ Zip: _____

Emergency Information

Contact Name: _____ Relationship: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

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How were you referred to our practice? ☐ Friend/family/former patient ☐ Internet ☐ Insurance ☐ Physician

☐ **Referring Physician (if selected above)**

Name:_____

Phone: _____ Specialty: _____

Other Healthcare Providers **PLEASE PUT CHECK MARK FOR MD YOU WOULD LIKE LETTERS SENT TO**

☐ **Primary Care Physician** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

☐ **Gastroenterologist** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

☐ **Cardiologist** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

☐ **Psychiatrist/Psychologist** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

☐ **Other MD (specialty: _____)** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

☐ **Other MD (specialty: _____)** **Last visit:** _____

Name:_____

Address:_____

Phone:_____ Fax:_____

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Date: _____ Age: _____

Present problem(s)/reason(s) for today's visit: _____

_____

_____

Medical Illnesses:

☐ Hypertension ☐ Coronary Artery Disease ☐ Stroke ☐ Kidney Disease ☐ Pacemaker
☐ Heart Attack ☐ Diabetes Mellitus ☐ DVT ☐ Heart Failure ☐ Adrenal

Past Surgeries:

Procedure	Date
_____	_____
_____	_____
_____	_____

Past Hospitalizations (Treatment other than surgeries)

Type	Date
_____	_____
_____	_____
_____	_____

Do you currently smoke? ☐ No ☐ Yes # cigarettes/day: _____ Age started: _____

Have you ever been a smoker? ☐ No ☐ Yes Age started: _____ Age quit: _____ # cigarettes\day: _____

Do you consume alcohol? ☐ No ☐ Yes Drinks/day: _____

Type of drinks: _____

Do you use recreational drugs? ☐ No ☐ Yes Type of drug(s) & frequency: _____

_____

_____

What type of work do you do? _____

What hobbies/activities do you enjoy? _____

Do you Exercise? ☐ No ☐ Yes Type: _____ Frequency: _____

Family Medical History Are you adopted? ☐ No ☐ Yes

Please list below any/all family members who have or have had the following:

Disease	**Family member(s):**	
☐ Stroke	_____	
☐ Heart disease	_____	
☐ Cancer	_____	Type: _____
☐ Diabetes	_____	Type: _____
☐ Other	_____	Type: _____

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Review of Symptoms/Medical Conditions (please check all that apply)

Constitutional:
☐ Chills ☐ Daytime sleepiness ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ None

Skin:
☐ Acne ☐ Skin ulcers ☐ Rash ☐ Color changes around neck, underarms, legs ☐ None

Cardiovascular/circulatory/blood:
☐ Anemia ☐ Blood clots ☐ Congestive heart failure ☐ Hypertension ☐ Stents
☐ Arrythmia ☐ Bruises/bleeds easily ☐ Heart attack (MI) ☐ Irregular heartbeat
☐ Bleeding disorder ☐ Cardiovascular disease ☐ Hypercholesterolemia ☐ Palpitations
☐ Blood transfusions ☐ Chest pain/pressure ☐ Hyperlipidemia ☐ Other ☐ Swelling of legs/feet

Respiratory/pulmonary:
☐ Asthma ☐ Cough with sputum ☐ Emphysema ☐ Sleep apnea
☐ Bronchitis ☐ Chronic cough ☐ Pulmonary embolism ☐ Snoring
☐ Choking/gasping ☐ COPD ☐ Shortness of breath ☐ Wheezing
Do you use CPAP? ☐ Yes ☐ No

Gastrointestinal:
☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Hiatal Hernia ☐ Nausea ☐ Vomiting
☐ Bloody Stools ☐ Dark stools ☐ GERD ☐ Indigestion/heartburn ☐ None ☐ Ulcers

Urinary:
☐ Blood in urine ☐ Incontinence ☐ Night-time frequency ☐ Pain with urination

Musculoskeletal:
☐ Arthritis ☐ Joint pain ☐ Leg cramps ☐ None ☐ Stiffness
☐ Back pain ☐ Joint swelling ☐ Musculoskeletal disease ☐ Osteoporosis

Endocrine:
☐ Cold Intolerance ☐ Excessive thirst ☐ Excessive hair ☐ Heat intolerance ☐ None
☐ Cushing's Disease ☐ Diabetes Mellitus ☐ Hair loss ☐ Hypo- or hyper-thyroidism ☐ PCOS
(☐ Oral or ☐ Injectable Insulin Date of diagnosis: _____)

Neurologic:
☐ Balance problems ☐ Dizziness ☐ Fainting ☐ Memory loss ☐ Stroke
☐ Chronic pain ☐ Epilepsy/Seizures ☐ Frequent headache ☐ Numbness or tingling ☐ Weakness

Liver/renal:
☐ Cirrhosis/liver disease ☐ Gout ☐ Renal insufficiency ☐ None
☐ Gallstone disease ☐ Kidney stones ☐ Renal failure/ESRD/dialysis

Psychological/Behavioral:
☐ Anorexia ☐ Binge Eating ☐ Bulimia ☐ Panic Attacks ☐ Sleeping difficulties ☐ None
☐ Anxiety ☐ Bi-polar disorder ☐ Depression ☐ Schizophrenia ☐ Suicidal thoughts

Gynecologic:
Date of last menstrual period:_____ Date of last gynecological exam:_____
Number of pregnancies: _____ Number of live births: _____ Births vaginal or C-section: _____

Immunologic/infectious:
☐ Auto-immune disease ☐ HIV ☐ AIDS ☐ Hepatitis ☐ None

Miscellaneous:
☐ Cancer (type):_____ Date of diagnosis: _____ Treatment:_____
☐ Cancer (type):_____ Date of diagnosis: _____ Treatment:_____
☐ Other:_____

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PATIENT MEDICATION / ALLERGY LIST

Pharmacy Name, address and phone number

PATIENT I.D.

PLEASE COMPLETE AND BRING ON THE DAY OF YOUR APPOINTMENT

Patient Name: _____ DOB: _____

DRUG ALLERGIES OR SENSITIVITIES: *Please List All Allergies To Drugs, Foods, Medical* **Dyes/Contrast, Or Any Other Sensitivities.**

1. _____
2. _____
3. _____
4. _____
5. _____

Please List All Current Medications Including Vitamins And Herbal Supplements

NAME OF MEDICATION, DOSE & FREQUENCY	START DATE	STOP DATE

(FILE ON LEFT SIDE OF CHART)

Form No. 8759 (Rev. 7/05)