

# PATIENT / FAMILY HISTORY

Le Sueur Clinic

Mayo Health System

625 South Fourth Street, Le Sueur, MN 56058  
Phone: 507-665-6299 Fax: 507-665-3799

## PATIENT PROVIDED INFORMATION

The information you provide us will greatly help us to provide the highest quality and comprehensive care for you.

Date \_\_\_\_\_ Gender  Male  Female Date of birth (Month/Day/Year) \_\_\_\_\_

### A. PAST MEDICAL HISTORY

1. Have you ever traveled or lived outside of the United States or Canada?  Do not know  No  Yes
2. Have you ever received a blood transfusion?  Do not know  No  Yes ☞ If yes, check all that apply.  
 Before 1980  1980-1990  After 1990

3. Have you received the following immunizations and/or had the disease?

Pneumococcal (For pneumonia)	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mumps	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hepatitis B	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rubella	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hepatitis A	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Polio	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Measles	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Varicella (For chicken pox)	<input type="checkbox"/> Do not know	<input type="checkbox"/> No	<input type="checkbox"/> Yes

4. Indicate whether you have ever had a medical problem or surgery related to each of the following. Check all that apply.

Medical Problem	Surgery/Year	Medical Problem	Surgery/Year
Eyes _____	<input type="checkbox"/> _____	Lungs _____	<input type="checkbox"/> _____
Ears _____	<input type="checkbox"/> _____	Esophagus (Food or swallowing pipe) _____	<input type="checkbox"/> _____
Nose _____	<input type="checkbox"/> _____	Stomach (Ulcer) _____	<input type="checkbox"/> _____
Sinuses _____	<input type="checkbox"/> _____	Bowel (Small or large intestine, rectum) _____	<input type="checkbox"/> _____
Tonsils _____	<input type="checkbox"/> _____	Appendix _____	<input type="checkbox"/> _____
Thyroid or parathyroid gland _____	<input type="checkbox"/> _____	Lymph nodes _____	<input type="checkbox"/> _____
Heart problems:		Spleen _____	<input type="checkbox"/> _____
Heart attack _____	<input type="checkbox"/> _____	Liver _____	<input type="checkbox"/> _____
Heart valves _____	<input type="checkbox"/> _____	Gallbladder _____	<input type="checkbox"/> _____
Abnormal heart rhythm _____	<input type="checkbox"/> _____	Pancreas _____	<input type="checkbox"/> _____
Narrowed coronary arteries _____	<input type="checkbox"/> _____	Hernia _____	<input type="checkbox"/> _____
Other _____	<input type="checkbox"/> _____	Kidneys _____	<input type="checkbox"/> _____
Arteries (Head, arms, legs, aorta, etc.) _____	<input type="checkbox"/> _____	Bladder _____	<input type="checkbox"/> _____
Veins or blood clots in the veins _____	<input type="checkbox"/> _____	Bones _____	<input type="checkbox"/> _____

(Label)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Unit No. \_\_\_\_\_

**A. PAST MEDICAL HISTORY (Continued)**

Medical Problem	Surgery/Year	Medical Problem	Surgery/Year
Joints _____	<input type="checkbox"/> _____	Spine _____	<input type="checkbox"/> _____
Muscles _____	<input type="checkbox"/> _____	Brain _____	<input type="checkbox"/> _____
Back _____	<input type="checkbox"/> _____	Skin _____	<input type="checkbox"/> _____
Neck _____	<input type="checkbox"/> _____	Breasts _____	<input type="checkbox"/> _____
Females:		Males:	
Uterus _____	<input type="checkbox"/> _____	Prostate _____	<input type="checkbox"/> _____
Ovaries _____	<input type="checkbox"/> _____	Penis _____	<input type="checkbox"/> _____
Fallopian tubes _____	<input type="checkbox"/> _____	Testicles _____	<input type="checkbox"/> _____
Hysterectomy _____	<input type="checkbox"/> _____	Vasectomy _____	<input type="checkbox"/> _____
Other _____	<input type="checkbox"/> _____	Other _____	<input type="checkbox"/> _____
			<input type="checkbox"/> None

5. Have you been hospitalized for any other surgeries **not** listed above?  No  Yes What was the problem? \_\_\_\_\_  
When? \_\_\_\_\_

**B. PERSONAL AND FAMILY HISTORY**

If known, complete the following information about your blood relatives (*Include children*).

6. Are you adopted?  No  Yes

7. Father:  Do not know

Alive

Deceased age at death:  Under 30  30-40

41-50  51-60  61-70  Over 70

Cause of death \_\_\_\_\_

8. Mother:  Do not know

Alive

Deceased age at death:  Under 30  31-40

41-50  51-60  61-70  Over 70

Cause of death \_\_\_\_\_

	0	1	2	3	4	5	6	7+	Do not know
9. Brothers: Number alive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number deceased:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Sons: Number alive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number deceased:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Sisters: Number alive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number deceased:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Daughters: Number alive:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number deceased:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Label)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Unit No. \_\_\_\_\_

**B. PERSONAL AND FAMILY HISTORY (Continued)**

To help us understand any special circumstances for your family, we need to know if you or any of your family has had any of the following. Please check the appropriate boxes. Identify **all** illnesses or conditions which you know have occurred in you or your blood relatives. Indicate "None" if you are unsure.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grand-parents	None
13. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Colon cancer/rectal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Colon polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Pancreatic cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Abnormal bleeding (Bleeding disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. High or low white count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Recreational/street drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Other psychiatric/mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Suicide (Or attempted suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Label)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Unit No. \_\_\_\_\_

**B. PERSONAL AND FAMILY HISTORY (Continued)**

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grand-parents	None
44. Anesthesia complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Genetic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Allergies/Allergic reactions (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Other (Discuss with care provider)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Provider Updates/Comments:** (Sign and Date)

\_\_\_\_\_  
(Signature of Person Completing Form)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Provider)

\_\_\_\_\_  
(Reviewed/Dated)

Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____