TRINITY DOCTORS GROUP, PA

Medical History Form

Name: _____ Age: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Location: _____ Phone: _____

List Any Allergies to Medications/Food and Reaction: ☐ **No Known Drug Allergies**

_____

List Current Medications Including Over the Counter Medications ☐ **No Current Medications**

Name Strength/Dosage Directions/Frequency

_____

_____

_____

Past Medical History: Do you have any medical problems listed below? What year did they occur?

☐ Allergies	☐ Cancer, (type_____)	☐ Asthma	☐ Thyroid Disease
☐ Anemia	☐ COPD (Emphysema)	☐ Heart Attack	☐ Enlarged Prostate
☐ Angina/Chest Pain	☐ Coronary Artery Disease	☐ Hepatitis	☐ Depression/Anxiety
☐ Blood Clots	☐ Diabetes	☐ Kidney Disease	☐ Migraines/Headaches
☐ Stroke, CVA/TIA	☐ Gallbladder Disease	☐ Kidney Stones	☐ Osteoporosis
☐ Seizure Disorder	☐ Arthritis/Joint Pain	☐ Goiter	☐ Diverticulitis/Diverticulosis
☐ High Cholesterol	☐ High Blood Pressure	☐ Constipation	☐ Diarrhea
☐ Rash	☐ Stomach Issues/Acid Reflux	☐ Other: _____	

Past Surgical History: Have you ever had any surgeries? What year did they occur? ☐ **None**

☐ Carpal Tunnel Release	☐ Hip Replacement- Right/Left	☐ Knee Replacement- Right/Left
☐ Heart Stent	☐ Cataract Surgery	☐ Knee Scope
☐ Heart Bypass	☐ Back Surgery	☐ Prostate Removal
☐ Pacemaker	☐ Gallbladder Removal	☐ Colon Resection
☐ Hernia Repair	☐ Fibroid Removal	☐ Appendix Removal
☐ Tonsil/Adenoid Removal	☐ Other: _____	

Female Only:

☐ Date of Last Period: _____ ☐ PAP: _____ ☐ Mammogram: _____

☐ Menopause ☐ C-Section ☐ Hysterectomy ☐ Breast Biopsy/Surgery

☐ Breast Augmentation ☐ Are you Pregnant? ☐ Are you nursing?

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Medical History Form (Cont.)

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Do you use tobacco? YES NO ☐ Do you consume Alcohol? YES NO ☐ Drugs? YES NO

☐ Do you have children? How Many? _____

☐ Occupation? _____

☐ Retired? What was your past profession? _____

Family Medical History

☐ **Adopted/Unknown**

	If Living Age	Medical Conditions	**If Deceased:** Age at Death	Cause of Death
Father:				
Mother:				
Brother(s):				
Sister(s):				

Preventive Care/Services

Please provide approximate dates of your last screening services:

☐ PSA (Prostate) _____

☐ Cholesterol _____

☐ Colonoscopy _____

Vaccines

☐ FLU _____ ☐ Pneumonia _____

☐ Shingles _____ ☐ Tetanus _____

Patient Signature: _____ **Date:** _____