Trinity Centre

Medical History

Date ____________________

Personal Information

Name____
Last *First* *MI*

Sex: Male Female

Age _____ Date of Birth ______

Single Married Divorced Widowed Separated

If married/partnered: spouse's name__________________________

Children's names and ages ____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ yes ☐ no

(If yes, please list name of medicine and type of reaction)

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

Past Medical History and Review of Systems

Please circle if you have had any problems with or are presently experiencing any of the following:

Heart
High Blood Pressure
Chest pain/chest tightness
Palpitations
Lightheadedness
Swollen ankles

MOOD
Depression
Kidney disease
Drug abuse
Anxiety
Insomnia
Alcohol abuse

Lungs
Bronchitis
Pneumonia
Shortness of breath
Asthma
Persistent cough

Endocrine
Diabetes
Thyroid disease
Anemia

Neuro
Headache
Weakness
Loss of Sensation

GI
Change in bowel habits
Abdominal discomfort
Hemorrhoids
Hepatitis or jaundice
Diarrhea/ Nausea
Gall Bladder disease
Blood in stool
Indigestion
Vomiting
Colitis

Arthritis
Low back problem
Gout
Muscle Pain
Joint Pain

GU
Frequent urination
UTI
Erectile Dysfunction

Skin
Psoriasis
Acne
Eczema

Cancer

Gynecologic and Obstetric History

Age at onset of periods _______________ Frequency ____________________ Length of period ___________________

Pregnancies ________________________ Births _______________________ Miscarriages _____________________

Prolonged or abnormal bleeding ____No ____Yes (Please Describe) ____

Leakage of urine ____No ____Yes (Please Describe) ____

Pelvic pain ____No ____Yes (Please Describe) ____

Abnormal discharge ____No ____Yes (Please Describe) ____

History of Abnormal Pap smear ____No ____Yes (Please Describe) ____

Please continue on the next page

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Medical History

Date ________________

Please List and Supply the Dates of:

Operations ______________________ ______________________ ______________________
______________________ ______________________ ______________________

Hospitalizations other than for surgery ______________________ ______________________
______________________ ______________________ ______________________

Immunization history—have you had: Please Circle if yes.
.Hepatitis A, Hepatitis B, Pneumonia vaccine, MMR, Tetanus HPV (Giardisil) Chickenpox Meningitis Herpes Zoster

When was your last:
Pap Smear? ____________________ Breast Exam? __________________ Colon Cancer Test? ________________
Mammogram? __________________ Cholesterol check? ______________ Prostate exam? ____________________

Family History

Has any member of your family (parents, grandparents, and siblings) ever had the following?

Illness	Which family member?	Age when diagnosed
Cancer (describe type)	______________________________	__________________________
Hypertension (high blood pressure)	______________________________	__________________________
Heart Disease	______________________________	__________________________
Diabetes	______________________________	__________________________
Strokes	______________________________	__________________________
Mental disease (anxiety, depression)	______________________________	__________________________
Drug or alcohol addiction	______________________________	__________________________
Glaucoma	______________________________	__________________________
Bleeding diseases	______________________________	__________________________
Other ______________________	______________________________	__________________________

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you exercise regularly? ___Yes ___No If yes, type, duration and number of times per week?
____

Did you /do you smoke? ___Yes ___No If yes, how many packs per day? How long?____________
Do you drink alcoholic beverages? ___Yes ___No If yes, how much per week? __________________________
Do you drink coffee or tea ___Yes ___No If yes, how many cups per day? ________________________
Do you use drugs? (marijuana, cocaine, etc) ___Yes ___No If yes, explain: ______________________________________
Have you ever engaged in any activity which has put you at risk of getting AIDS? ___Yes ___No If yes, explain:
____

Do you wish to be tested for AIDS? ___Yes ___No

Method of birth control? ____