TRINITY COMMUNITY CARE

Patient Health History

Clinic Use Only:

PRN: _____

MRN: _____

Date: _____ Age: _____ Sex: ☐ M ☐ F

Name: _____ Birth Date: _____ SSN: _____

Last First M.I.

PERSONAL HEALTH HISTORY

Immunizations (please check immunizations and list date received):

☐ Tetanus	☐ Hepatitis B	☐ Pneumonia	☐ Chicken Pox
☐ Hepatitis A	☐ Influenza (Flu)	☐ MMR	☐ Other: _____

Last Physical Examination:

Date:	By:	Where:

Last Dental Examination:

Date:	By:	Where:

Emergency Room visits (please list all Emergency Room visits within the past 2 years):

Date/ Reason/ Hospital:

Hospitalizations (please list all hospitalizations):

Date/ Event/ Hospital:

Surgeries (please check surgeries and list date)

☐ Appendix	☐ Heart Bypass	☐ Mastectomy/ Breast Biopsies	☐ Other:_____
☐ Gall Bladder	☐ Hysterectomy	☐ Tonsils	☐ Other:_____

Medications (please list all medications you are currently taking - including prescription & over-the-counter medications, vitamins, supplements, & herbals) :

Medication/ Dosage/ Frequency:	Reason for taking:

Allergies (please list all allergies – medication, food, latex, and/ or environmental):

Allergic to:	Reaction you had:

Past Medical History - Do you currently have or have you had:

☐ AIDS	☐ Bronchitis	☐ Glaucoma	☐ HIV Positive	☐ Pacemaker	☐ Thyroid Problems
☐ Alcoholism	☐ Bulimia	☐ Goiter	☐ Kidney Disease	☐ Pneumonia	☐ Tonsillitis
☐ Anemia	☐ Cancer	☐ Gonorrhea	☐ Liver Disease	☐ Polio	☐ Tuberculosis
☐ Anorexia	☐ Cataracts	☐ Gout	☐ Measles	☐ Prostrate Problem	☐ Typhoid Fever
☐ Appendicitis	☐ Chemical Dependency	☐ Heart Disease	☐ Migraine Headaches	☐ Psychiatric Care	☐ Ulcers
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Miscarriage	☐ Rheumatic Fever	☐ Vaginal Infections
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Mononucleosis	☐ Scarlet Fever	☐ Venereal Disease
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Multiple Sclerosis	☐ Stroke	☐ Other: _____
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Mumps	☐ Suicide Attempt	☐ Other: _____

TRINITY COMMUNITY CARE

Patient Health History

Clinic Use Only:

PRN: _____

MRN: _____

Current Symptoms – Are you currently experiencing or have you experienced in the past year:

General:

☐ Chills ☐ Headache
☐ Depression ☐ Nervousness
☐ Dizziness ☐ Numbness
☐ Fainting ☐ Sleep Loss
☐ Fever ☐ Sweats
☐ Forgetfulness ☐ Weight Gain/Loss

Gastrointestinal:

☐ Appetite Poor ☐ Hemorrhoids
☐ Bloating ☐ Indigestion
☐ Bowel Changes ☐ Nausea
☐ Constipation ☐ Rectal Bleeding
☐ Diarrhea ☐ Stomach Pain
☐ Excessive Hunger ☐ Vomiting
☐ Excessive Thirst ☐ Vomiting Blood
☐ Gas

Eyes, Ears, Nose, & Throat:

☐ Bleeding Gums ☐ Hoarseness
☐ Blurred Vision ☐ Hearing Loss
☐ Crossed Eyes ☐ Nosebleeds
☐ Difficulty Swallowing ☐ Persistent Cough
☐ Double Vision ☐ Ringing in Ears
☐ Earache ☐ Sinus Problems
☐ Ear Discharge ☐ Vision – Flashes
☐ Hay Fever ☐ Vision - Halos

Muscles, Joints, & Bones
(Pain, Weakness, or Numbness in):

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

Cardiovascular:

☐ Chest Pain ☐ Poor Circulation
☐ High Blood Pressure ☐ Rapid Heart Beat
☐ Irregular Heartbeat ☐ Swelling of Ankles
☐ Low Blood Pressure ☐ Varicose Veins

Skin:

☐ Bruise Easily ☐ Rash
☐ Hives ☐ Scars
☐ Itching ☐ Sore That Won't Heal
☐ Change in Moles

Pulmonary (Lungs):

☐ Cough ☐ Pain with Cough ☐ Shortness of Breath
☐ Coughing Up Blood ☐ Productive Cough ☐ Wheezing

Genitourinary:

☐ Blood in Urine ☐ Lack of Bladder Control
☐ Frequent Urination ☐ Painful Urination

Men Only:

☐ Breast Lump ☐ Lump in Testicles ☐ Penis Discharge ☐ Sore on Penis ☐ Erection Difficulties

Women Only:

☐ Abnormal Pap Smear ☐ Breast Lump ☐ Nipple Discharge ☐ Extreme Menstrual Pain
☐ Bleeding Between Periods ☐ Hot Flashes ☐ Painful Intercourse ☐ Vaginal Discharge

Menstrual Flow: ☐ Regular ☐ Irregular ☐Pain/Cramps # of days of flow: _____ Length of cycle: _____ Date of Last: _____

Number of : Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Date of Last: Pap Test: _____ ☐ Normal ☐ Abnormal Mammogram: _____ ☐ Normal ☐ Abnormal

FAMILY HEALTH HISTORY

Please indicate if any blood relative has history of illness and which relative (M = mother, F = father, S = sibling, G = grandparent)

☐ Alcoholism _____ ☐ Cancer _____ ☐ Hay Fever _____ ☐ Mental Illness _____
☐ Anemia _____ ☐ Depression _____ ☐ Heart Disease _____ ☐ Migraines _____
☐ Arthritis _____ ☐ Diabetes _____ ☐ Hepatitis _____ ☐ Osteoporosis _____
☐ Asthma/Allergy _____ ☐ Epilepsy _____ ☐ High Blood Pressure _____ ☐ Stroke _____
☐ Bleeding Disorder _____ ☐ Glaucoma _____ ☐ Lipid Disorder _____ ☐ Thyroid Disease _____

HEALTH HABITS & PERSONAL SAFETY

Alcohol: Do you drink alcohol? ☐Yes ☐No
If Yes, What kind? How many drinks per day? Per week?

Tobacco: Have you ever used tobacco? ☐Yes ☐No
What kind? How much? How long? When did you quit?

Drugs: Do you use recreational or street drugs of any kind? ☐Yes ☐No
What kind? How much?

Caffeine: ☐None ☐Coffee, # per day: ☐Tea, # per day: ☐Cola, # per day:

Exercise: ☐None ☐Mild (climb stairs, walk) ☐Occasional Vigorous (30 minutes, < 4x/ week) ☐Regular Vigorous (30 minutes, ≥ 4x/ week)

Diet: Are you dieting? ☐Yes ☐No with medical supervision? ☐Yes ☐No
How many meals to you eat in an average day?

Sex: Are you sexually active? ☐Yes ☐No

Personal Safety: Do you live alone? ☐Yes ☐No Do you have frequent falls? ☐Yes ☐No
Do you have vision or hearing loss? ☐Yes ☐No

Patient Signature: _____ Date: _____