TRINITY MEDICAL GROUP

PATIENT MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

PLEASE INDICATE (SIGN AND DATE BELOW)

PLEASE CIRCLE IF YOU HAVE HAD PROBLEMS WITH OR ARE PRESENTLY EXPERIENCING OF ANY OF THE FOLLOWING:

High Blood Pressure
Heart Disease
Swollen Ankles
Frequent Urination
Bronchitis
Tuberculosis
Indigestion
Constipation
Ulcers
Gallbladder Disease
Hepatitis or Jaundice
Headache
Difficulty Urinating
Skin Disease
Anxiety
Alcohol Abuse
Diabetes
Chest Pain
Palpitations
Rheumatic Fever
Pneumonia
Abdominal Pain
Nausea
Diarrhea
Gout
Unexplained Weight Gain/Loss
Thyroid Disease
Kidney Disease
Arthritis
Blood Disorders
Depression
Cancer
Shortness of Breath
Light Headedness
Asthma
Drug Abuse
Hay Fever
Vomiting
Blood In Stool
Hemorrhoids
Colitis
Head and Neck Radiation
Kidney Stones
Low Back Problems
Anemia
Change in Bowl Habits

IMMUNIZATION HISTORY

Pneumovax: NO _____ YES _____ When: _____

Hepatitis B: NO _____ YES _____ When: _____

Flu: NO _____ YES _____ When: _____

PLEASE LIST SURGERIES AND ANY COMPLICATIONS YOU HAVE HAD:

_____

_____

_____

MEDICATIONS: (PLEASE INCLUDE PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS & VITAMINS)

_____

_____

_____

Do you take any type of blood thinners? : NO _____ YES _____

ALLERGIES: (PLEASE CIRCLE)

Adhesive Tape
Penicillin
Sulfa
Local Anesthetics
Codeine
Iodine
Novocain Aspirin
Seafood
Other : _____
Latex
Demerol

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to administer and perform such procedures as may be deemed necessary in the diagnosis/treatment.

PATIENT'S/GUARANTOR'S SIGNATURE _____ DATE _____