Trivas Family Medicine
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Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	☐ None ☐ Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements) ☐ None ☐ Yes (please list)	

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y			N	Y
Hepatitis B Series				Recent Pneumonia Vaccine		
Gardasil Series				Recent Flu Vaccine		
Chicken Pox immunization or disease				Positive TB Screening		

Health Maintenance	No	Yes	(Year)			No	Yes	(Year)
Colonoscopy					Bone Density			
Mammogram					Eye Exam			
Pap Smear					Physical Exam			

Social History	No	Yes	
Smoking			Pack(s)/day /years ☐ Quit
Alcohol			Drinks/day drinks/week
Caffeine			Drinks/day
Recreational Drugs			
Special Diet			If yes describe:
Regular Exercise			If yes describe:
Sexually Active			☐ Men ☐ Women ☐ Both

GYN History	OB History
Age of first mensus: ( ) Menopause ☐ N ☐ Y (if yes Age:)	Total Number of Pregnancies: ( )
Regular Periods ☐ N ☐ Y Painful Periods ☐ N ☐ Y	Full Term ( ) Pre Term ( )
PMS ☐ N ☐ Y – if yes describe	Miscarriages ( ) Abortions ( )
Abnormal Pap: – if Yes approximate date ( )	Tubal ( )
Pain with intercourse: ☐ N ☐ Y	Content with sex life: ☐ N ☐ Y

Medical History (please check if positive)

ENT		GASTROINTESTINAL		HEMATOLOGICAL	
	Eye Problems		Acid Reflux		Anemia
	Sinus Problems		Constipation		Bleeding Disorders
	Hearing Loss		Diarrhea		Blood Clots
			Irritable Bowel		Cancer
CARDIOVASCULAR			Gall Bladder Disease		Sickle Cell Disease
	Abnormal EKG		Hernia	**ENDOCRINE**	
	Chest Pain		Liver Disease		Diabetes
	Heart Attack	**GENITOURINARY**			Thyroid Disease
	Heart Disease		Urinary Infections		Pancreatitis
	High Blood Pressure		Kidney Disease/Stones	**SKIN**	
	High Cholesterol		Erectile Dysfunction		Psoriasis
	Stroke		STD		Skin Disorders
	Peripheral Vascular Disease		Urinary Incontinence		Melanoma
PULMONARY		**MUSCULOSKELETAL**		**PSYCH**	
	Asthma		Arthritis/Osteo		ADD / ADHD
	Emphysema/COPD		Arthritis/Rheumatoid		Anxiety
	Shortness of Breath		Gout		Depression
	Sleep Apnea		Neck/Spinal Problems		Memory Loss
		NEUROLOGICAL			OCD
			Concussion		Suicidal Thoughts / Attempt
			Headaches		
			Migraines		
			Epilepsy/Seizures		

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Other
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									