HERITAGE VALLEY MEDICAL GROUP
TRINITY FAMILY PRACTICE
2580 Constitution Boulevard
Beaver Falls, PA 15010
(724) 773-6844

MEDICAL HISTORY

Date: / /

Name______________________ Age__________ Birthdate__________

Address______________________ Sex: ☐ Male ☐ Female

______________________ Home Phone (______) __________

______________________ Work Phone (______) __________

Occupation______________________ Emergency contact__________

Phone (______)__________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name______________________

Children's names and ages______________________

ALLERGIES TO MEDICATIONS, X-RAYS, DYES OR OTHER SUBSTANCES ☐ NO ☐ YES

(If yes, please list name of medicine and type of reaction): **LATEX ALLERGY?** ☐ NO ☐ YES

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

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

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Light-headedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. Chicken Pox
50. __________

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)__________

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PATIENT NAME Date: / /

PLEASE LIST AND SUPPLY THE DATES OF:

Operations: ____________ ____________ ____________

____________ ____________ ____________

Hospitalizations other than for surgery: ____________ ____________

____________ ____________ ____________

Immunization history: Have you had:

Hepatitis B? ☐ No ☐ Yes When?__________

Other?__________ ☐ No ☐ Yes When?__________

Pneumovax immunization? ☐ No ☐ Yes When__________

Flu immunization? ☐ No ☐ Yes When__________

Tetanus immunizations? ☐ No ☐ Yes When__________

When was your last:

Testicular Exam?__________ Last Menstrual Period?__________

Pap smear? __________ Breast Exam?__________ Stool check for blood?__________

Mammogram?__________ Cholesterol check?__________ Prostate exam?__________

Colonoscopy?__________ Eye exam?__________ Dental Exam?__________

FAMILY HISTORY

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

Illness	Which Family Members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding disease		
Other:__________		

MEDICATIONS (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

PREVENTION

Do you wear seatbelts? ☐ No ☐ Yes If no, why not?__________

Do you smoke? ☐ No ☐ Yes How many packs?__________

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week?__________

Do you drink coffee? ☐ No ☐ Yes If yes, how many cups per day?__________

Do you drink tea? ☐ No ☐ Yes If yes, how many cups per day?__________

If there is a gun in your home, is it out of children's reach and unloaded? ☐ No ☐ Yes ☐ N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain__________

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain__________

Do you wish to be tested for AIDS? ☐ No ☐ Yes __________

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain__________

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes

Do you have a "living will"? ☐ No ☐ Yes

Do you have a donor card? ☐ No ☐ Yes

Method of birth control?__________

Patient Signature

____

Physician Signature