Trinity Medical Care, PC – HEALTH HISTORY

Name:____________________________ Birthdate: __________ __Today's date:________________

Height:____________Weight:___________Allergies:____

Medical Problems:_______________________________________ __________________________________

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Medications and dose:_______________________________________ ________________________________

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Surgeries:____

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SOCIAL HISTORY:

Tobacco Use:_________________________________Alcohol Use: ______________________

Exercise: What kind?_________________________How often?_________________________ _______

FAMILY MEDICAL HISTORY (no need to write names,only the medical history):

Mother:____ ____ ________

Father: _ ____ _ _______

Siblings: How many brothers? Sisters?_______Any medical Problems?_______________ ______

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How many children? Any medical Problems?____ _______

Last Tetanus Vaccine:____________________Have you had chicken pox?____________________________

Do you have a Living Will, Healthcare Proxy, Advance Directive, etc.?______If not, would you like more information? **Y or N**