Triad Adult and Pediatric Medicine

Patient Medical History Information

Patient Name: ____ **Date of Birth** ___/____/_______

Date Form Completed: ____/____/_____

Please list all allergies including medicines, foods, environmental and betadine:

____
____
____

Please list all current medications and over the counter medications:

Medicine Name	Mg	Dosage Schedule

Patient Social History

Tobacco Use: Check answers and fill in blanks as needed

___ Yes ___ Passive ___Quit ____Never

Cigarette packs/day ______ Years Smoke ______ Date quit______

Other types: ___ Pipe ____ Snuff ____Cigar ____Chew

Alcohol Use: ____ Yes ____ No If yes, how many ounces per week? _____________

Drug Use: ____ Yes ____ No ___ Use IV If yes, how many times per week? _____________

Sexual Activity: ___Yes ____ No If yes, partner is: ___ Male ____ Female

Birth Control;/Protection:

___Condom ____ IUD ____Implant ____Sponge ____Pill ____Surgical ____Rhythm ____Inserts

____Diaphragm ____Spermicide ____Injection

Marital Status:

____Single ____ Married ___Partnered ____ Separated ___Divorced ____Widowed

Do you have, or have you had any of the following health conditions? ***(Please check all that apply)***

○ Diabetes (Sugar) ○ High Blood Pressure ○ Asthma/Emphysema ○ Heart Attack ○ Heart Disease ○ Stroke ○ Cancer ○ Seizures ○ Kidney Disease ○ Kidney Stones ○ Arthritis ○ Osteoporosis ○ Mental Illness ○ Alcoholism	○ Allergy ○ Hay Fever ○ Pneumonia ○ Broken Bones ○ Skin Diseases ○ Gout ○ Hepatitis ○ Peptic Ulcer ○ Vaginal Infection ○ Sexually Transmitted Disease ○ Anemia ○ High Cholesterol ○ Blood Transfusion	○ Thyroid ○ Other (Please Describe: ____________________________ ____________________________ ____________________________ ____________________________ ____________________________

Please check the box for any family members listed that have had any of the following health problems:

MGM&MGF= Your Mother's parents **PGM&PGF=Your Father's parents**

	Father	**Mother**	**Sister**	**Brother**	**MGM**	**MGF**	**PGM**	**PGF**
Diabetes(Sugar)								
High Blood Pressure								
Asthma/Emphysema								
Heart Attack								
Heart Disease								
High Cholesterol								
Breast Cancer								
Colon Cancer								
Prostate cancer								
Thyroid								
Seizures								
Kidney Disease								
Kidney Stone								
Arthritis								
Osteoporosis								
Mental Illness								
Alcoholism								
Stroke								
Alive								
Deceased								

Other Health Maintenance Screenings

Date of your last Colonoscopy ____/_____/______

Date of your last Eye Exam ____/_____/______

Date of your last foot exam ____/_____/______

FEMALE PATIENTS ONLY

What year was your last delivery? ___________ Period/Menstrual Cycle _____Regular ____Irregular

First day of last period (date) ____/_____/_____ Date of last pap smear ____/_____/_____

Total # of pregnancies____ Total # Live Births _____ Total # of Miscarriages/stillbirths_____

Total # abortions _______

Date of last mammogram ____/_____/_____

All Patient Prior Surgeries:

Please check all that apply and list the year the surgery was performed.

○ Appendectomy ________ ○ Arthroscopy_________ Site______ ○ Back Surgery _______ ○ Bunions ______ ○ Cataracts Removed ________ ○ Carotid Bypass _____ ○ Coronary Bypass _______ ○ Fractured Repair _________ Site_____________ ○ Hernia Repair ______ Site______________ ○ Gallbladder Removed ______	○ Hemorrhoid _____ ○ Joint Replaced ____ Site______________ ○ Hysterectomy ______ ○ Prostate Surgery ________ ○ Polyps Removed ________ ○ Sinus________ ○ Tonsillectomy __________ ○ Thyroid Removal _________ ○ Vasectomy ________ ○ Tubal Ligation _________ ○ Other: Please List: ________________________________ ________________________________

Staff Only Below this line:

Provider Signature: ____________________________ Date Reviewed: ______________________