Trinity Heritage Clinic

DEMOGRAPHICS

Patient's Name (First, Middle, Last): _____Date of Birth: _____

Address: _____

City: _____ State: ____ Zip Code: _____ Email: _____

Cell Phone#: _____ Home Phone #:_____ Work#: _____

Sex: ☐ Male ☐ Female SS#: _____ Are you employed? ☐ Full Time ☐ Part-Time ☐ Retired ☐Disabled

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed How did you hear about us? _____

Ethnicity: ☐Asian ☐Black or African American ☐Caucasian ☐ Hispanic Other:_____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Pharmacy Name: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: _____ Group#: _____

Secondary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: _____ Group#: _____

OTHER HEALTH CARE PROVIDERS

	Type of Practitioner (e.g., PCP, Cardiologist, Podiatrist, etc)	Name	Office Use
1.			☐ ___
2.			☐ ___
3.			☐ ___
4.			☐ ___
5.			☐ ___
6.			
7.			
8.			

PERSONAL HISTORY

I HAVE NO PAST MEDICAL HISTORY ☐

EYES/EAR/NOSE/THROAT
- Cataracts ☐
- Glaucoma ☐
- Macular Degeneration ☐
- Hearing loss ☐
- Cold sores (canker sores) ☐

CARDIOVASCULAR
- Heart attack/Heart disease ☐
- Heart murmur ☐
- High blood pressure ☐
- Pacemaker ☐
- PAD (Peripheral artery disease) ☐

PULMONARY
- Asthma ☐
- COPD / Emphysema ☐
- Pneumonia ☐

GASTROINTESTINAL
- Colon polyps ☐
- Hemorrhoids ☐
- Diverticulosis ☐
- Liver disease ☐
- Reflux (GERD) ☐
- Ulcers (stomach, duodenal) ☐

GENITOURINARY
- Kidney/bladder infections ☐

MUSCULOSKELETAL/RHEUM
- Arthritis ☐
- Gout ☐

SKIN
- Eczema/Dry skin (circle one) ☐
- Psoriasis ☐

NEUROLOGIC
- Headaches ☐
- Seizures/Fits/Epilepsy ☐
- Stroke ☐

PSYCHIATRIC/DEPENDENCY
- ADD/ADHD ☐
- Alcohol/Drug Dependency ☐
- Anxiety ☐
- Bipolar Disorder ☐
- Depression ☐
- Eating disorder: anorexia/bulimia ☐
- Suicide attempt ☐

ENDOCRINE
- Diabetes (sugar) ☐
- Hyperthyroid (high thyroid) ☐
- Hypothyroid (low thyroid) ☐
- High cholesterol ☐
- Infertility (pregnancy problems) ☐
- Osteoporosis /Osteopenia ☐

BLOOD/LYMPHATIC/CANCER
- Anemia/Low blood counts ☐
- Blood clots ☐
- Cancer: (Type: _____) ☐
- Easy bleeding ☐
- Sickle cell anemia ☐
- Transfusion ☐

ALLERGIC/IMMUNOLOGIC
- Hay fever/Pollen allergy ☐

INFECTIONS
- AIDS/HIV ☐
- Genital infections (e.g., herpes, chlamydia/gonorrhea, warts) ☐
- Hepatitis: Select Type ☐
- Measles/Mumps/Rubella ☐
- Rheumatic fever ☐
- Shingles ☐
- Tuberculosis (TB) ☐

MEN ONLY
- Enlarged prostate (BPH) ☐
- Erectile dysfunction/impotence ☐
- Prostatitis ☐

WOMEN ONLY
- Menopausal symptoms ☐
- Abnormal uterine bleeding ☐
- Endometriosis ☐
- Premenstrual Syndrome (PMS) ☐

Other medical history: _____

Family History

	High Blood Pressure	Diabetes	High Cholesterol	Heart Disease/CAD	Heart Attack	Stroke	Depression/Anxiety/Bipolar	Cancer (please specify type)	Kidney disease	Alcohol/Drug dependency	COPD/Emphysema	Other
Father												
Mother												
Sister												
Brother												
PGM												
PGF												
MGM												
MGF												

MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother, PGF= Paternal Grandfather

MEDICATIONS

Please bring your medications in the bottles or a complete medication list to your appointment.

If there are more than 10 medications please attach a list.

Do you have problems remembering to take your medications? ☐ Yes ☐ No

	Medication Name	Dosage	Times Per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

MEDICATION ALLERGIES

NO KNOWN ALLERGIES ☐

	Medication Name	Reaction	Age When Occurred
1.			
2.			
3.			
4.			

Have you had any significant hospitalizations? If so, please specify:

	Reason for Hospitalization	Year
1.		
2.		
3.		

SURGICAL HISTORY

SURGICAL HISTORY	DATE	SURGICAL HISTORY	DATE
Angioplasty/Stent	_____	Gastric bypass	_____
CABG (Heart bypass)	_____	Heart Valve	_____
Defibrillator	_____	Hernia repair	_____
Appendectomy	_____	Hysterectomy	_____
Knee Replacement	_____	Mastectomy	_____
Hip Replacement	_____	Thyroidectomy	_____
Back Surgery	_____	Tonsillectomy	_____
Carpal tunnel release	_____	Pacemaker	_____
Cataract extraction	_____	Prostate surgery	_____
Fracture	_____	Biopsy (location)	_____
Gallbladder Removal	_____		

Other _____

SOCIAL HISTORY

Have you experienced a fall in past 12 months? ☐ Yes ☐ No If yes, how many times have you fallen? _____

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

If yes, please bring copies. If no, are you interested in completing one? ☐ Yes ☐ No

Living arrangements (check all that apply)

☐ I live with my spouse/partner ☐ I live alone ☐ I live alone but have friends who check on me regularly

☐ I have family close by who can help me ☐ Assisted Living/Group Home ☐ Nursing Home

Are you sexually active? ☐ Yes ☐ No ☐ Men Only ☐ Women Only ☐ Both Men and Women

# of partners in the last 12 months: ☐ 1 ☐ 2 ☐ 3 ☐ ≥3 Do you always use protection? ☐ Yes ☐ No

WOMEN ONLY

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

When was your last menstrual period? _____

Do you use contraception? ☐ Yes ☐ No If yes, what? _____

DEPRESSION SCREENING				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

ALCOHOL AND DRUG HISTORY					
In the past month… (circle the appropriate answers)					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	≥ 4 times a week
How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	≥ 10
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Almost daily

Do you currently smoke?	Yes ◯	No ◯	How much? _____ cigarettes/day **OR** _____ packs/day How many years have you smoked this much? _____
Are you a former smoker?	Yes ◯	No ◯	I quit in _____ but smoked _____ packs a day for _____ yrs
Have you ever used street drugs?	Yes ◯	No ◯	What drugs? _____

Have you had any of the following? (*if yes, enter date to those that apply*)

Test	**Date**	**Test**	**Date**
Eye exam	_____	Tdap (Tetnus)	_____
Cholesterol Test	_____	Pneumovax	_____
Sleep study	_____	Prevnar 13	_____
Stool blood test	_____	Influenza (Flu Shot)	_____
Colonoscopy	_____	Zostavax (shingles shot)	_____
Bone Density	_____	Hepatitis B Vaccine	_____
Heart Stress Test	_____	Mammogram	_____
Prostate exam	_____	Pap Smear	_____
PSA Test	_____		

Other _____

Signature_____ Date:_____