Trinity Family Physicians

Let Our Family Care for Yours

Clinical Summary

Welcome to our practice. Please answer all the questions found below to the best of your ability.

Name: _____ **Date:** _____

Reason for today's visit: _____

Allergies to any medications: _____

Previous Hospitalizations/Surgeries/Procedures:	When:	Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a colonoscopy: YES or NO If so, when: _____ Doctor_____

FOR WOMEN ONLY

1. Last Pap Smear: _____ Do you have a GYN: _____ If so, who_____
2. Are your periods normal: _____
3. Last menstrual period: _____
4. Number of pregnancies:_____ vaginal deliveries: _____C-Sections: _____
5. Last Mammogram: _____
6. Last Bone Density Screening: _____

_____

Initials

Trinity Family Physicians

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Medication List for: _____

Please list your current medications:

❑ **Currently, I am NOT on any medication.**

Name	Strength	Cap/Tab/Other?	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

_____

Initials

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PATIENT HISTORY SHEET

Name: _____

PAST MEDICAL HISTORY:

- ☐ ABDOMINAL AORTIC ANEURYSM
- ☐ ABNORMAL PAP SMEAR (female)
- ☐ ATTENTION DEFICIT DISORDER
- ☐ ADOPTED
- ☐ ALLERGIC RHINITIS
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BACK PAIN
- ☐ BLOOD TRANSFUSION
- ☐ BENIGN PROSTATIC HYPERTROPHY
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ CANCER: BLADDER
- ☐ CANCER: BONE
- ☐ CANCER: BREAST
- ☐ CANCER: COLON
- ☐ CANCER: LEUKEMIA
- ☐ CANCER: LUNG
- ☐ CANCER: LYMPHOMA
- ☐ CANCER: MELANOMA
- ☐ CANCER: MOUTH
- ☐ CANCER: OVARIAN (female)
- ☐ CANCER: PROSTATE (male)
- ☐ CANCER: RENAL CELL
- ☐ CANCER: SKIN
- ☐ CANCER: TESTICULAR (male)
- ☐ CANCER: THYROID
- ☐ CANCER: UTERINE (female)
- ☐ CARDIOMYOPATHY
- ☐ CARPAL TUNNEL
- ☐ CATARACTS
- ☐ CVA (STROKE)
- ☐ CHRONIC BLADDER INFECTIONS
- ☐ CHRONIC DIARRHEA
- ☐ CHRONIC PANCREATITIS
- ☐ CIRRHOSIS
- ☐ COLOSTOMY
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ CORONARY ARTERY DISEASE
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ DIVERTICULOSIS
- ☐ DNR (DO NOT RESUSCITATE)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ EDEMA
- ☐ EMPHYSEMA
- ☐ GALLBLADDER DISEASE

_____
Initials

Name: _____

☐ GERD
☐ GOUT
☐ HEAD OR NECK RADIATION
☐ HEADACHE
☐ HEART DISEASE
☐ HEART MURMUR
☐ HYPERTENSION (High blood pressure)
☐ HERNIA
☐ HYPOTHYROIDISM
☐ HYPERLIPIDEMIA (High cholesterol)
☐ INSOMNIA
☐ MACULAR DEGENERATION
☐ MIGRAINE HEADACHE
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPENIA
☐ OSTEOPOROSIS
☐ PALPITATIONS
☐ PNEUMONIA
☐ POLIO
☐ PULMONARY NODULE
☐ PULMONARY EMBOLUS
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SEIZURES
☐ THYROID NODULE
☐ TIA (Transient ischemic attack aka mini-stroke)
☐ ULCERS
☐ URINARY INCONTINENCE
☐ UTERINE PROLAPSE (female)
☐ VERICOSE VEINS
☐ OTHER: _____
_____

☐ NONE OF THE ABOVE

SOCIAL HISTORY:

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, PACKS PER DAY: ☐ ONE ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU USE CAFFEINE? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

_____
Initials

Name: _____

FAMILY HISTORY:

MOTHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

FATHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
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- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

SIBLINGS: # BROTHERS ____ # SISTERS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
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- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

CHILDREN: # BOYS ____ # GIRLS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

_____
Initials

Name: _____

REVIEW OF SYSTEMS:

Which of the following symptoms have you had in the past **2 weeks**?

- ☐ FEVERS OR SWEATS
- ☐ VISION WORSENING
- ☐ HEARING LOSS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ BLOOD IN STOOL
- ☐ BLOOD IN URINE
- ☐ JOINT SWELLING
- ☐ IRRITATED MOLES
- ☐ CONVULSIONS
- ☐ LACK OF PLEASURE/FUN
- ☐ HOT FLASHES
- ☐ BRUISING EASILY
- ☐ WHEEZING
- ☐ SEX LIFE COULD BE BETTER
- ☐ UNDESIRED WEIGHT LOSS
- ☐ DOUBLE VISION
- ☐ DIFFICULTY SWALLOWING
- ☐ CHEST HEAVINESS
- ☐ COUGHING UP BLOOD
- ☐ VOMITING BLOOD
- ☐ URINARY DISCHARGE
- ☐ MUSCLE WEAKNESS
- ☐ CHANGING MOLES
- ☐ FALLING
- ☐ THOUGHTS OF SUICIDE
- ☐ CAN'T TOLERATE HOT/COLD TEMP
- ☐ BLEEDING FREQUENTLY
- ☐ NASAL CONGESTION
- ☐ SNORING

☐ NONE OF THE ABOVE

_____
Initials