Dr. Elizabeth A. Triana M.D. FAAFP

Please Help Us Update Your Medical Record By Filling This Form Out Completely. ☺

Patient Name: _____ D.O.B. _____

Social History

Marital Status: Married/ Single/ Widowed/ Divorced/ Engaged/ Significant Other

Do you have any biological children, if so, please specify age and gender of each:

_____

_____

Who do you live with? _____

Do you have any pets? If so, please specify: _____

What is your occupation? _____

Nutritional status: Poor/ Fair/ Good/ Excellent/ Vegetarian

Do you exercise? If so, please specify type and duration:

_____

_____

Sexual Activity: Not sexually active/ Monogamist/ Multiple Partners

Contraceptive Use: None/ Oral Contraceptive/ Family Planning/ Condoms

Intrauterine Device/ Hysterectomy/ Vasectomy/ Abstinence

Smoking Status: If so, please include history, duration and amount per day:

_____

_____

Alcohol Status: If so, please include history, duration and amount per day:

_____

_____

Do you use illicit drugs? _____

Do you wear your seatbelt? _____

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Past Medical History

Please list any diseases or health related problems that you have (including but not limited to high blood pressure, high cholesterol, coronary artery disease, strokes, kidney disease, anxiety/depression, osteoporosis, arthritis, or any other disease processes.)

_____

_____

_____

_____

_____

_____

Surgeries or Medical Procedures

Please list any surgeries or medical procedures that you have had in the past and the approximate year of the procedure.

_____

_____

_____

_____

_____

_____

Additional Information (Woman Only)

How many times have you been pregnant? _____

How many children do you have? _____

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Family History (Please Circle)

Mother: Deceased or Alive

History Of:
Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid disorder: Please specify: _____

Father: Deceased or Alive

History Of:
Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid disorder: Please specify: _____

Siblings: Brothers: 1, 2, 3, 4 or _____ Sisters: 1, 2, 3, 4 or _____

Deceased or Alive

Please comment on each of your sibling's medical history below.

_____

_____

_____

_____

_____

_____

_____

_____

Extended Family History:

Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Hypertension
Depression
Kidney Disease
Stroke