TRISTAR MEDICAL GROUP FAMILY PHYSICIANS

Responsible Party	
Name	
Address	
Phone	
Birth Date	
Social Security Number	
Patient Information	
Name	
Address	
Phone	
Cell Phone	
Email Address	
Birth Date	
Sex	
Marital Status	
Age	
Social Security #	
Emergency Name	
Emergency Phone	

Section must be completed:

1) **Race:** ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Unreported/Refused to Report
2) **Ethnicity (Cultural Background):** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report
3) **Language:** ❑ English; ❑ Spanish; ❑ Indian; ❑ Japanese; ❑ Chinese; ❑ Korean; ❑ French; ❑ German; ❑ Russian; ❑ Other _____

Health Insurance	
Name of Insured	
Patient Relationship to Insured	
Birth Date	
Primary Insurance Company	
Primary Claim Address	
Primary Phone	
Primary Policyholder	
Primary Subscriber #	
Primary Group #	
Primary Insurance Copay	
Specialty Insurance Copay	
Secondary Insurance Company	
Secondary Subscriber #	
Secondary Group #	
Pharmacy Name	
Pharmacy Phone#	

How did you hear about us?

❑ Referring Provider ❑ Website ❑ HealthGrades.com ❑ Family/Friends ❑ Blog
❑ Search Engine ❑ Facebook ❑ Yelp.com ❑ Physician Directory ❑ Twitter
❑ Google Places Page ❑ Vitals.com ❑ Other

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim.

X	Date

New Patient Info Form

Patient: _____ **DOB** _____ **Ht:** _____ **Wt:** _____ **Temp:** _____
Date: _____ **Hp:** _____/_____ **Pulse:** _____

HISTORY

CHIEF COMPLAINT:

HISTORY of PRESENT ILLNESS: • For an "Extended" history, document at least four of these elements

- **Location** _____ (Where is the pain/problem?)
- **Quality** _____ (Example: color of sputum)
- **Severity** _____ (How severe is the pain/problem?)
- **Duration** _____ (How long have you had this pain/problem? or when did it start?)
- **Timing** _____ (Does this pain/problem occur at a specific time?)
- **Context** _____ (Where were you at the onset of this pain/problem?)
- **Associated signs/symptoms** _____ (What other associated problems have you been having?)
- **Modifying factors** _____ (What makes this pain/problem worse or better? or have you had any previous episodes?)

MEDICAL HISTORY:

• For a "Pertinent" history - at least 1 specific item for ANY ONE of the 3 histories
• For a "Complete" history - at least 1 specific item for EACH ONE of the 3 histories

• *Patient Medical History*

Diabetes	**No**	**Yes**	**Previous Hospitalizations/Surgeries/Serious Injuries** **When?**
Hypertension	**No**	**Yes**	_____
Cancer	**No**	**Yes**	_____
Stroke	**No**	**Yes**	_____
Heart trouble	**No**	**Yes**	_____
Arthritis/gout	**No**	**Yes**	
Convulsions	**No**	**Yes**	**Medications**
Bleeding tendency	**No**	**Yes**	_____
Acute infections	**No**	**Yes**	_____
Venereal disease	**No**	**Yes**	_____
Hereditary defects	**No**	**Yes**	_____

• *Patient social history*

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Use of alcohol: Never ____ Rarely ____ Moderate ____ Daily ____
Use of tobacco: Never ____ Previously, but quit ____ Current packs/day ____
Use of drugs: Never ____ Type/Frequency _____
Excessive exposure at home or work to: Fumes ____ Dust ____ Solvents ____ Air-borne particles ____ Noise ____

• *Family Medical History*

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

SYSTEM REVIEW:

Document the positive & pertinent negative responses
- For an "EXTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state: "All other systems negative")

- **CONSTITUTIONAL SYMPTOMS**
  - Good general health lately ..... No Yes
  - Recent weight change ..... No Yes
  - Fever ..... No Yes
  - Fatigue ..... No Yes
  - Headaches ..... No Yes

- **EYES**
  - Eye disease or injury ..... No Yes
  - Wear glasses/contact lenses ..... No Yes
  - Blurred or double vision ..... No Yes
  - Glaucoma ..... No Yes

- **EARS/NOSE/MOUTH/THROAT**
  - Hearing loss or ringing ..... No Yes
  - Earaches or draining ..... No Yes
  - Chronic sinus problems or rhinitis ..... No Yes
  - Nose bleeds ..... No Yes
  - Mouth sores ..... No Yes
  - Bleeding gums ..... No Yes
  - Bad Breath or bad taste ..... No Yes
  - Sore throat or voice change ..... No Yes
  - Swollen glands in neck ..... No Yes

- **CARDIOVASCULAR**
  - Heart trouble ..... No Yes
  - Chest pain or angina pectoris ..... No Yes
  - Palpitation ..... No Yes
  - Shortness of breath with walking or lying flat ..... No Yes
  - Swelling of feet, ankles or hands ..... No Yes

- **RESPIRATORY**
  - Chronic or frequent coughs ..... No Yes
  - Spitting up blood ..... No Yes
  - Shortness of breath ..... No Yes
  - Asthma or wheezing ..... No Yes

- **GASTROINTESTINAL**
  - Loss of appetite ..... No Yes
  - Change in bowel movements ..... No Yes
  - Nausea or vomiting ..... No Yes
  - Frequent diarrhea ..... No Yes
  - Painful bowel movements or constipation ..... No Yes
  - Rectal bleeding or blood in stool ..... No Yes
  - Abdominal pain or heartburn ..... No Yes
  - Peptic ulcer (stomach or duodenal) ..... No Yes

- **GENITOURINARY**
  - Frequent urination ..... No Yes
  - Burning or painful urination ..... No Yes
  - Blood in urine ..... No Yes
  - Change in force of strain when urinating ..... No Yes
  - Incontinence or dribbling ..... No Yes
  - Kidney stones ..... No Yes
  - Sexual Difficulty ..... No Yes
  - Male - testical pain ..... No Yes
  - Female - pain with periods ..... No Yes
  - Female - irregular periods ..... No Yes
  - Female - vaginal bleeding ..... No Yes
  - Female - # of pregnancies _____ # of miscarriages _____
  - Female - date of last pap smear _____

- **MUSCOLOSKELETAL**
  - Joint Pain ..... No Yes
  - Joint Stiffness ..... No Yes
  - Weakness of muscles or joints ..... No Yes
  - Muscle pain or cramps ..... No Yes
  - Back pain ..... No Yes
  - Cold extremities ..... No Yes
  - Difficulty in walking ..... No Yes

- **INTEGUMENTARY (skin, breast)**
  - Rash or itching ..... No Yes
  - Change in skin color ..... No Yes
  - Change in hair or nails ..... No Yes
  - Varicose Veins ..... No Yes
  - Breast Pain ..... No Yes
  - Breast lump ..... No Yes
  - Breast discharge ..... No Yes

- **NEUROLOGICAL**
  - Frequent or recurring headaches ..... No Yes
  - Light headed or dizzy ..... No Yes
  - Convulsions or seizures ..... No Yes
  - Numbness or tingling sensations ..... No Yes
  - Tremors ..... No Yes
  - Paralysis ..... No Yes
  - Stroke ..... No Yes
  - Head Injury ..... No Yes

- **PSYCHIATRIC**
  - Memory loss or confusion ..... No Yes
  - Nervousness ..... No Yes
  - Depression ..... No Yes
  - Insomnia ..... No Yes

- **ENDOCRINE**
  - Glandular or hormone problem ..... No Yes
  - Thyroid disease ..... No Yes
  - Diabetes ..... No Yes
  - Excessive thirst or urination ..... No Yes
  - Heat or cold intolerance ..... No Yes
  - Skin becoming dryer ..... No Yes
  - Change in hat or glove size ..... No Yes

- **HEMATOLOGIC/LYMPHATIC**
  - Slow to heal after cuts ..... No Yes
  - Bleeding or bruising tendency ..... No Yes
  - Anemia ..... No Yes
  - Phlebitis ..... No Yes
  - Past transfusion ..... No Yes
  - Enlarged glands ..... No Yes

- **ALLERGIC/IMMUNOLOGIC**
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics ..... No Yes
    - Morphine, Demerol, or other narcotics ..... No Yes
    - Novocaine or other anesthetics ..... No Yes
    - Aspirin or other pain remedies ..... No Yes
    - Tetanus antitoxin or other serums ..... No Yes
    - Iodine methiolate or other antiseptics ..... No Yes
  - Other drugs/medications _____
  - Known food allergies _____

Thank you for choosing our office!

How did you hear about us? ***please circle***

Word Of Mouth / Friend and Family

Insurance

Physician Referral _____

Signage

Minute Clinic located @ _____

Care Spot located @ _____

The Little Clinic located @ _____

Advertising

Online / Internet _____

Other _____

Patient Name: _____

Date of Birth: _____/_____/_____