TRI STAR MEDICAL GROUP
Sterling Primary Care

Date: _____

Patient Name: _____ **Date of Birth:** ___ / ___ / ___
(Last) (First) (Middle)

Name of Doctor Being Seen:

_____

Preferred Pharmacy:

Name: _____

Address: _____

Phone: _____

Additional Physicians/Specialists You See Regularly:

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

Name: _____ Specialty: _____ Location: _____

REASONS FOR YOUR APPOINTMENT:

1. _____

2. _____

3. _____

PAST MEDICAL HISTORY: Please select your current medical conditions.

Hypertension (High Blood Pressure)	☐YES	☐NO
Diabetes (High Blood Sugar)	☐YES	☐NO
COPD (emphysema, chronic bronchitis)	☐YES	☐NO
High Cholesterol	☐YES	☐NO
Heart Disease	☐YES	☐NO
Anxiety	☐YES	☐NO
Depression	☐YES	☐NO
Thyroid Disorder	☐YES	☐NO

Please list your other medical conditions:

_____ _____

_____ _____

_____ _____

MEDICATIONS: List your current medications. Include aspirin, birth control pills, nutritional supplements, and over-the-counter medicines you use regularly.

☐ Check here if you brought a medication list. Please give list to your nurse.

1. _____
   Name of Medication Dosage Amount How Often Taken
2. _____
   Name of Medication Dosage Amount How Often Taken
3. _____
   Name of Medication Dosage Amount How Often Taken
4. _____
   Name of Medication Dosage Amount How Often Taken
5. _____
   Name of Medication Dosage Amount How Often Taken
6. _____
   Name of Medication Dosage Amount How Often Taken
7. _____
   Name of Medication Dosage Amount How Often Taken
8. _____
   Name of Medication Dosage Amount How Often Taken

*Note: Please check here ☐ if you have additional medicines. Ask nurse for additional paper if needed.

ALLERGIES: Medication/Food Type of Reaction

1. _____

2. _____

3. _____

If needed, list additional allergies here: _____

PAST SURGICAL HISTORY: List your past surgeries.

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

PRIOR HOSPITALIZATIONS: List specific hospitals and reason for hospitalization.

1. _____ Month/Year _____
2. _____ Month/Year _____
3. _____ Month/Year _____

FAMILY HISTORY:

List family members who have had the following:

Diabetes: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart attacks: _____
Strokes: _____
Asthma/COPD: _____
HIV or AIDS: _____
Stomach/Colon Problems: _____
Psychiatric Disorders (i.e. anxiety, depression): _____
Bleeding Disorder or Anemia: _____
Cancer:

Relation Type (i.e. breast, prostate, etc.)

_____
_____
_____

List additional conditions you consider significant:_____

OB/GYN HISTORY: Please complete if female.

Number of Pregnancies: _____
Number of Miscarriages, Abortions, Stillbirths: _____
Do you currently use contraception/birth control? ☐YES ☐NO
If yes, what type? _____
Do you see an OBGYN regularly? ☐YES ☐NO If yes, whom do you see? _____

PERSONAL HISTORY:

Occupation: _____
Education: *List highest level attained* _____
Marital Status: _____
Spouse's Occupation: _____
Children (include names and age):

_____ _____ _____

PERSONAL HISTORY (continued):

Health Habits:

1. Alcohol use:
   - Do you drink alcohol? ☐YES ☐NO
   - How many drinks per week? _____
   - Do you drink alcohol daily? ☐YES ☐NO
     - What type, how much? _____
2. Smoking:
   - Are you are smoker? ☐YES ☐NO
   - If yes, how many packs per day? _____
   - If a former smoker, what year did you quit? _____
3. Illicit drug use (such as marijuana, cocaine, methamphetamines, etc.):
   - What type? _____
   - How often? _____
4. Exercise:
   - Do you exercise regularly? ☐YES ☐NO
5. Diet:
   - Are you satisfied with your diet? ☐YES ☐NO
   - How much water do you drink daily? _____
   - How many cups of coffee or tea per day? _____
6. Sleep:
   - Hours of sleep per day _____

PREVENTIVE CARE:

If applicable, please provide the approximate date of your last…	Obtained Where?
Pap Smear: _____	_____
Mammogram: _____	_____
Colonoscopy: _____	_____
Eye Exam: _____	_____
Bone Density (DEXA) Scan: _____	_____

Have you received the following immunizations?		List Date if known:
Influenza/Flu	☐YES ☐NO	_____
Pneumonia	☐YES ☐NO	_____
Tetanus	☐YES ☐NO	_____
Pertussis	☐YES ☐NO	_____
HPV/Gardasil	☐YES ☐NO	_____
Hepatitis A	☐YES ☐NO	_____
Hepatitis B	☐YES ☐NO	_____
Shingles	☐YES ☐NO	_____

Patient Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

REVIEW OF SYSTEMS:
Please place a checkmark next to any symptom you are currently experiencing:

General	Weight Loss ☐ Weight Gain ☐ Fever ☐ Night Sweats ☐ Fatigue ☐ None ☐
Eyes	Blurry Vision ☐ Loss of Vision ☐ Eye Pain ☐ Eye Redness ☐ Dry Eyes ☐ None ☐
ENT	Sore Throat ☐ Sinus Trouble ☐ Hoarse Voice ☐ Hearing Loss ☐ Ringing in Ears ☐ Ear Pain ☐ Tooth Problems ☐ None ☐
Cardiovascular	Chest Pain ☐ Rapid Heartbeat ☐ Murmur ☐ Leg Swelling ☐ Leg Pain when Walking ☐ None ☐
Respiratory	Shortness of Breath ☐ Cough ☐ Sputum Production ☐ Coughing up Blood ☐ None ☐
Gastrointestinal	Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Blood in Stool ☐ Frequent Heartburn ☐ Trouble Swallowing ☐ None ☐
Genitourinary	Burning with Urination ☐ Increased frequency ☐ Urgency Incontinence ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Vaginal Discharge ☐ Breast Lump or Pain ☐ None ☐
Musculoskeletal	Joint Pain ☐ Muscle Pain ☐ Muscle Weakness ☐ Back Pain ☐ None ☐ *If so, list where:* _____
Endocrine	Increased Thirst ☐ Excessive Sweating ☐ Heat Intolerance ☐ Cold Intolerance ☐ Poor appetite ☐ Irregular Menstrual Periods ☐ None ☐
Neurologic	Headaches ☐ Tremor ☐ Tingling/Numbness ☐ Dizziness ☐ Speech Difficulty ☐ None ☐
Psychiatric	Anxiety ☐ Depression ☐ Panic Attacks ☐ Alcohol/Drug Dependence ☐ Suicidal Thoughts ☐ Work/Home Life Unpleasant ☐ None ☐ *If you suffer from any of the above, do you desire psychiatric help:* ☐*YES* ☐*NO*
Hematologic/ Lymphatic	Easy Bruising ☐ Swollen Lymph Nodes ☐ None ☐
Skin	Changes in Moles ☐ Skin Problems ☐ Rash ☐ Itching ☐ Hair Loss ☐ None ☐

Please list any additional symptoms you feel pertinent to your medical health:

_____ _____ _____ _____ _____

Patient Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____