TriStar Family Care
New Patient Health History

Name:_____ DOB:_____/_____/_____ Date:_____/_____/_____

Occupation:_____

What are you here for today?_____

Do you or any family members have history of the following medical issues? Please mark (X)

	Self	Father	Mother	Sibling (bro/sis)	Children (son/dau)	Other (who?)
Heart Disease	☐	☐	☐	☐____	☐____	☐_____
Stroke	☐	☐	☐	☐____	☐____	☐_____
High Blood Pressure	☐	☐	☐	☐____	☐____	☐_____
High Cholesterol	☐	☐	☐	☐____	☐____	☐_____
Diabetes	☐	☐	☐	☐____	☐____	☐_____
Asthma	☐	☐	☐	☐____	☐____	☐_____
Emphysema	☐	☐	☐	☐____	☐____	☐_____
Migraines	☐	☐	☐	☐____	☐____	☐_____
Seizures	☐	☐	☐	☐____	☐____	☐_____
Depression	☐	☐	☐	☐____	☐____	☐_____
Anxiety	☐	☐	☐	☐____	☐____	☐_____
Chronic Pain	☐	☐	☐	☐____	☐____	☐_____
Arthritis	☐	☐	☐	☐____	☐____	☐_____
Cancer	☐	☐	☐	☐____	☐____	☐_____
Thyroid Issue	☐	☐	☐	☐____	☐____	☐_____
Drug/Alcohol Abuse	☐	☐	☐	☐____	☐____	☐_____
Other (specify)	☐	☐	☐	☐____	☐____	☐_____

Have you had any surgeries? If so, what surgeries and when did you have them?

What medications do you take, including over the counter vitamins and supplements?

Name	Dose	Frequency	Name	Dose	Frequency

Do you have any allergies? If so, what type of reaction occurs? (e.g. rash, swelling)

_____

_____

Do you smoke? (Please Circle): Current/Never/Quit in_____
How much do/did you smoke? _____packs per day for _____ years.
Do you drink? How much and how often? _____
Do you use drugs of any kind? _____

When was the last time you had the following:

Pap smear	_____	Pneumonia vaccine	_____
Mammogram	_____	Shingles vaccine	_____
Prostate exam	_____	Tetanus shot	_____
Colonoscopy	_____	Flu vaccine	_____
Bone density scan	_____	Cholesterol check	_____
Thyroid exam	_____		

In the past week, have you had any of the listed symptoms?

- ☐ Unintentional weight change
- ☐ Fever
- ☐ Chills/night sweats
- ☐ Blurry vision
- ☐ Double vision
- ☐ Runny nose
- ☐ Sore throat
- ☐ Cough
- ☐ Wheezing
- ☐ Trouble breathing
- ☐ Low energy
- ☐ Palpitations
- ☐ Chest pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Frequent nighttime urination
- ☐ Vaginal/Penile discharge
- ☐ Muscle pains
- ☐ Joint pains
- ☐ Limb Weakness/numbness
- ☐ Seizures
- ☐ Depressed mood
- ☐ Anxiety
- ☐ Trouble sleeping
- ☐ Unexplained bruising
- ☐ Unexplained bleeding
- ☐ Rash

What pharmacy would you like to use?
Name:_____
Location:_____
Phone Number:_____