

# TRISTAR MEDICAL GROUP STONECREST 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:	
<b>1) Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unreported/Refused to Report	
<b>2) Ethnicity (Cultural Background):</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Refused to Report	
<b>3) Language:</b> <input type="checkbox"/> English; <input type="checkbox"/> Spanish; <input type="checkbox"/> Indian; <input type="checkbox"/> Japanese; <input type="checkbox"/> Chinese; <input type="checkbox"/> Korean; <input type="checkbox"/> French; <input type="checkbox"/> German; <input type="checkbox"/> Russian; <input type="checkbox"/> 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?**

- |   |                                     |   |  |                                  |
|---|-------------------------------------|---|--|----------------------------------|
| <input type="checkbox"/> Referring Provider | <input type="checkbox"/> Website    | <input type="checkbox"/> HealthGrades.com | <input type="checkbox"/> Family/Friends      | <input type="checkbox"/> Blog    |
| <input type="checkbox"/> Search Engine      | <input type="checkbox"/> Facebook   | <input type="checkbox"/> Yelp.com         | <input type="checkbox"/> Physician Directory | <input type="checkbox"/> Twitter |
| <input type="checkbox"/> Google Places Page | <input type="checkbox"/> Vitals.com | <input type="checkbox"/> 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.

<b>X</b>	Date
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# New Patient Info Form

Patient: \_\_\_\_\_ DOB \_\_\_\_\_  
 Date: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Temp: \_\_\_\_\_  
 Hp: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

## HISTORY

### CHIEF COMPLAINT:

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

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• <b>Location</b> _____<br/>(Where is the pain/problem?)</li> <li>• <b>Severity</b> _____<br/>(How severe is the pain/problem?)</li> <li>• <b>Timing</b> _____<br/>(Does this pain/problem occur at a specific time?)</li> <li>• <b>Associated signs/symptoms</b> _____<br/>(What other associated problems have you been having?)</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Quality</b> _____<br/>(Example: color of sputum)</li> <li>• <b>Duration</b> _____<br/>(How long have you had this pain/problem? or when did it start?)</li> <li>• <b>Context</b> _____<br/>(Where were you at the onset of this pain/problem?)</li> <li>• <b>Modifying factors</b> _____<br/>(What makes this pain/problem worse or better? or have you had any previous episodes?)</li> </ul> |
|--|--|

### 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
Hypertension .....	No	Yes
Cancer .....	No	Yes
Stroke .....	No	Yes
Heart trouble .....	No	Yes
Arthritis/gout .....	No	Yes
Convulsions.....	No	Yes
Bleeding tendency .....	No	Yes
Acute infections .....	No	Yes
Venereal disease .....	No	Yes
Hereditary defects .....	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries	When?
_____	_____
_____	_____
_____	_____

**Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### • 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

	<u>Age</u>	<u>Disease</u>	<u>If Deceased, Cause of Death</u>
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 \_\_\_\_\_

• **MUSCULOSKELETAL**

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 \_\_\_\_\_