



# Tri-Area Community Health

Tri-Area Community Health Centers

Ferrum                      Floyd                      Laurel Fork  
540-365-4469              540-745-9290              276-398-2292

NAME \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ PHONE # \_\_\_\_\_

Marital Status:  Married     Separated    Your Spouses Name \_\_\_\_\_  
 Single         Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

**Please list any medications you are taking now:**

Medication	Strength	Dosage	Taken Medicine Since

**Which Pharmacy Do You Want To Use?**

Tri-Area Pharmacy, Laurel Fork, 276/398-2292    or     Tri-Area Pharmacy, Ferrum, 540-365-MEDS (6637)  
 Other (Location/Phone) \_\_\_\_\_

## MEDICAL HISTORY

List any drug or food allergies: \_\_\_\_\_  
\_\_\_\_\_

List any serious medical problems you have had in the past: \_\_\_\_\_  
\_\_\_\_\_

List any serious medical problems for which you are currently under the care of another physician: \_\_\_\_\_  
\_\_\_\_\_

List any serious childhood illness or injuries: \_\_\_\_\_  
\_\_\_\_\_

List any hospitalizations or surgical procedures: \_\_\_\_\_  
\_\_\_\_\_

List any injuries, broken bones, amputations or accidents: \_\_\_\_\_  
\_\_\_\_\_

If applicable, total # of pregnancies: \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_

# Tri-Area Community Health

NAME: \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

## Are you bothered with any of the following problems?

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Nosebleeds                         |
| <input type="checkbox"/> Swallowing         | <input type="checkbox"/> Swelling of feet or ankles         |
| <input type="checkbox"/> Choking            | <input type="checkbox"/> Weakness in Hands or Feet          |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Numbness/Tingling in Hands or Feet |
| <input type="checkbox"/> Increased Appetite | <input type="checkbox"/> Passing out Spells                 |
| <input type="checkbox"/> Stomach Pain       | <input type="checkbox"/> Chest Pain                         |
| <input type="checkbox"/> Loose Stool        | <input type="checkbox"/> Loss of Appetite                   |
| <input type="checkbox"/> Blood in Stool     | <input type="checkbox"/> Vomiting                           |
| <input type="checkbox"/> Blood in Urine     | <input type="checkbox"/> Easily Tired                       |

List any pain you are experiencing: \_\_\_\_\_

**Rate Your Pain:** On a scale of 1 – 10 (*10 being the worst*), how severe is your pain? 1 2 3 4 5 6 7 8 9 10

Have you had any of these test or immunization in the past 5 years? (List the date, if known)

Pap \_\_\_\_\_ Mammogram \_\_\_\_\_ PSA \_\_\_\_\_ EKG \_\_\_\_\_

Chest X-Ray \_\_\_\_\_ Stool for Blood \_\_\_\_\_ Tetanus, Flu, Pneumonia, or Hepatitis A, B \_\_\_\_\_

## FAMILY HISTORY:

Do you have a family history of any of the following?

- Cancer     High Blood Pressure     Heart Disease     Diabetes  
 Other: \_\_\_\_\_

List all members of your immediate family and your relationship to them: \_\_\_\_\_

## SOCIAL HISTORY:

Have you ever smoked or chewed tobacco?  yes  no    If so, how much a day? \_\_\_\_\_

Have you ever used any street drugs? \_\_\_\_\_

Have you ever drunk alcohol?  yes  no    If so, how much? \_\_\_\_\_ How many years? \_\_\_\_\_

Have you quit?  yes  no    Would you like help quitting? \_\_\_\_\_

## IF YOU ARE A VETERAN, PLEASE FILL OUT THE FOLLOWING INFORMATION:

What branch of the military were you in? \_\_\_\_\_

Where were you stationed? \_\_\_\_\_ # years in the service \_\_\_\_\_

List any illness or injury you experience while in the military: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_