GRAVES GILBERT CLINIC Family Care Center
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SCAN NUMBER:

New Patient Health Information

Name: ____ Date of Birth: ___/___/____ Today's Date: ___/___/____

Medical History: Please circle *or list* any medical condition that applies to you

diabetes high blood pressure high cholesterol heart attack/blockage previous stroke atrial fibrillation migraines
depression / anxiety under / over-active thyroid chronic back pain pain management Rheumatism Cancer (list type)

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Surgical History: Please circle *or list* any previous surgery you have had (including the year it was done if known)

gallbladder _____ appendix _____ hysterectomy / ovaries removed _____ tonsils / adenoids removed _____
thyroid removed _____ L/R breast removed _____ back/neck surgery _____ weight loss surgery _____ knee replacement _____

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Family History: Please circle any *listed* health conditions that exist in *these members* of your family if applicable

Father:	heart attack	stroke	diabetes	cancer__________________________	other ________________________________
Mother:	heart attack	stroke	diabetes	cancer__________________________	other ________________________________
Brother:	heart attack	stroke	diabetes	cancer__________________________	other ________________________________
Sister:	heart attack	stroke	diabetes	cancer__________________________	other ________________________________

Personal History: Please circle and/or complete all that apply to you

Occupation (former if retired or disabled): _______________________________ Retired Disabled Student ________________

Married: Yes to _________________________ No Divorced ____ time(s) Number of children: ______

Nicotine: Never smoked Current smoker ____ packs/day for ____ years Former smoker ____ packs/day for ____ years
Never used tobacco Currently: vape chew/dip ____ times per week Formerly: vape chew/dip ____ times per week

Alcohol: Never Occasionally Rarely Often: ____ drinks per week Recovering alcoholic

I.V. drugs: Never Currently use IV drug: _____________________________ Former IV drug use: ______________________________

Medications: Please list ***ALL*** medications you take, including non-prescription and herbal supplements

Drug	**Strength**	***Directions / times per day***	**Drug**	**Strength**	***Directions / times per day***
__________________	_______________	______________________	_______________	_______________	______________________
__________________	_______________	______________________	_______________	_______________	______________________
__________________	_______________	______________________	_______________	_______________	______________________
__________________	_______________	______________________	_______________	_______________	______________________
__________________	_______________	______________________	_______________	_______________	______________________
__________________	_______________	______________________	Additional meds written on back of page (circle this please)		

Allergies / adverse reactions: Please list any allergy or reaction to medications *OR* foods that apply to you

Medication / Food / Other	***Reaction** (e.g., rash, swelling)*	**Medication / Food / Other**	***Reaction** (e.g., rash, swelling)*
_________________________	______________________________	______________________	______________________________
_________________________	______________________________	______________________	______________________________
_________________________	______________________________	Additional reactions written on back of page (circle this please)	

Pharmacy: Please indicate the pharmacies to where you would like your prescriptions sent electronically

Local: ____ **Mail Order**: ____