Clifton Comprehensive Medical Center

New Patient Medical History

Name: ________________________________ Date: _______________
Date of Birth: _______/_______/ _______ Age: _______ Sex: _______
How did you hear about our practice?

Please state the reason for your visit

Past Medical Problems			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***

Past Surgical Procedures / Hospitalizations			
Operation / Hospitalization	***Month / Yr***	***Operation / Hospitalization***	***Month / Yr***

Previous Physicians and Specialists

Medication or Food Allergies or Intolerances *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Medications, Vitamins and Herbal Supplements					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

Social, Educational and Work History

Marital Status:	List the age of your children, if any?	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Do you live in a nursing home or assisted living facility?
Highest Level of Education:	What are your hobbies?	
What type of exercises do you perform, duration & frequency?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	# of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active:	How many partners have you had during the past 12 months?	
Are you concerned that you may have been exposed to HIV? Yes / No		

Family Health History

Relative	*Living or Deceased*	*Age at death, if applicable*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

Review of Systems

Please circle any of the following symptoms which you experience

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

Others? **Disease Prevention and Health Maintenance**

Please list below the MOST RECENT dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Heart Stress Test	
Shingles Vaccine		Bone Density		HIV Test	