Community Care Internal Medicine Clifton Park
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New Patient History

Name: _____ Date of Birth: _____ Date: _____

Please be as accurate as you can. Approximate dates or years. If you don't know an answer, write "?" in the space provided.

MEDICATIONS / VITAMINS / SUPPLEMENTS

DRUG	DOSE (STRENGTH)	FREQUENCY (HOW OFTEN)

MEDICAL PROBLEMS THAT YOU HAVE NOW

MEDICAL PROBLEMS OR INJURIES THAT YOU HAD IN THE PAST

WHAT PROBLEM?	APPROXIMATELY WHEN?

ALLERGIES

SUBSTANCE FOR MEDICATION	REACTION (WHAT HAPPENS?)

Name: _____ Date of Birth: _____ Date: _____

SURGERIES (Operations)	
WHAT OPERATION?	**APPROXIMATELY WHEN?**

FAMILY HISTORY	
	LIST HEALTH PROBLEMS
Mother	
Father	
Sisters (How Many?)	
Brothers (How Many?)	
Children (How Many?)	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

SOCIAL HISTORY		
TOBACCO USE?	Y / N	What Type?
How Long?		When did you last use?
ALCOHOL USE?	Y / N	What type?
How Much?		How Often?
EXERCISE?	Y / N	What type?
How Long?		How Often?
Have you used any drugs not prescribed by a physician? Y / N		
If yes - What type?		
Who else lives in your household?		

OCCUPATION	
What do you do now?	How long have you done it?
What have you done the longest?	How long did you do it?

IMMUNIZATIONS (Check any immunizations you had and give the approximate dates if known)

	Influenza		Pneumovax		Zostavax		Tetanus
	Hepatitis A		Hepatitis B		MMR		Gardisil
	Polio		Meningococcus		Hemophilus		Other: _____

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date